Florida Medicaid Reform

Quarterly Progress Report
April 1, 2009 – June 30, 2009

1115 Research and Demonstration Waiver

Agency for Health Care Administration

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

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I. Waiver History

Background

Florida's Medicaid Reform is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system. The program is operated under an 1115 Research and Demonstration Waiver approved by the Centers for Medicare and Medicaid Services (CMS) on October 19, 2005. State authority to operate the program is located in Section 409.91211, Florida Statutes, which provides authorization for a statewide pilot program with implementation that began in Broward and Duval Counties on July 1, 2006. The program expanded to Baker, Clay and Nassau Counties on July 1, 2007.

Through mandatory participation for specified populations in managed care plans that offer customized benefit packages and an emphasis on individual involvement in selecting private health plan options, the State expects to gain valuable information about the effects of allowing market-based approaches to assist the state in its service to Medicaid beneficiaries.

Key components of Medicaid Reform include:

- Comprehensive Choice Counseling;
- Customized Benefit Packages;
- Enhanced Benefits for participating in healthy behaviors;
- Risk Adjusted Premiums based on enrollee health status;
- Catastrophic Component of the premium (i.e., state reinsurance to encourage development of provider service networks and health maintenance organizations in rural and underserved areas of the State); and
- Low-Income Pool.

The reporting requirements for the 1115 Medicaid Reform Waiver are specified in Section 409.91213, Florida Statutes, and Special Term and Conditions # 22 and 23 of the waiver. Special Term and Condition (STC) # 22 requires that the State submit a quarterly report upon implementation of the program summarizing the events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans, specifying coverage area, phase-in, populations served, and benefits, enrollment, grievances, and other operational issues. This report is the fourth quarterly report in Year Three of the demonstration for the period of April 1, 2009 through June 30, 2009. For detailed information about the activities that occurred during previous quarters of the demonstration, refer to the quarterly and the annual reports which can be accessed at: http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml.

II. Status of Medicaid Reform

A. Health Care Delivery System

1. Health Plan Contracting Process

Overview

All health plans, including contractors wishing to participate as Medicaid Reform health plans, are required to complete a Medicaid Health Plan Application. In 2006, one application was developed for both capitated applicants and fee-for-service (FFS) provider service network (PSN) applicants. The health plan application process focuses on four areas: organizational and administrative structure; policies and procedures; on-site review; and contract routing process. In addition, capitated health plans are required to submit a Customized Benefit Plan to the Agency for approval as part of the application process. Customized Benefit Plans are described on pages 9 through 13 and are an integral part of the demonstration. FFS PSNs are required to provide services at the state plan level, but may (after obtaining state approval) eliminate or reduce co-payments and may offer additional services. Under current state law (as adopted during the 2009 Florida Legislative Session), the demonstration FFS PSNs are also required to become capitated after the fifth year of operations (for most PSNs, this is September 1, 2011).

The Agency uses an open application process to procure health plans. This means there is no official due date for submission in order to participate as a health plan in Broward, Duval, Baker, Clay or Nassau County. Instead, the Agency provides guidelines for application submission dates in order to ensure that applicants fully understand the contract requirements when preparing their applications. The health plan applications are reviewed and processed in four phases as described below.

- Phase I encompasses a review of the organizational structure of the applicant.
- Phase II focuses on review of financial information, ensuring provider network adequacy, and approving policies and procedures for all aspects of contract compliance.
- Phase III is comprised of the on-site survey and any necessary follow-up.
- Phase IV includes contract execution, establishing a provider file in the Florida Medicaid Management Information System, completing systems testing to ensure the health plan applicant is capable of submitting and retrieving HIPAA-compliant files and submitting accurate provider network files, and ensuring the health plan receives its first membership.

Current Activities

Since the beginning of the demonstration, the Agency has received 22 health plan applications (15 HMOs and 7 PSNs) of which 20 applicants sought and received approval to provide services to the TANF and SSI population. Of the 22 health plan applications received, all but two were approved as health plans as of June 30, 2009.

The most recent application was received January 14, 2009, from Sunshine State Health Plan, an HMO. Sunshine State Health Plan was approved in May 2009, with its first enrollment scheduled for July 2009. In addition, Sunshine State Health Plan has requested to expand into Baker, Clay and Nassau Counties. .

The two health plan applications still pending were submitted by HMOs: AIDS Healthcare Foundation, Inc., a specialty plan (HMO) for beneficiaries living with HIV/AIDS, and Medica Health Plans of Florida. AIDS Healthcare Foundation, Inc., doing business as Positive Health Care, submitted its application in January 2008, to serve beneficiaries living with HIV/AIDS. This application is the second specialty plan application the Agency has received (the first being the specialty plan for children with chronic conditions which became operational in 2006). As of June 30, 2009, the specialty plan application was nearing completion of Phase III of the application process. Medica Health Plans of Florida is an HMO with a national base. As of June 30, 2009, this HMO application was in Phase II of the application process.

Molina Health Plan (HMO) has entered into an agreement with NetPass Health Plan (FFS PSN) and the NetPass membership is scheduled to be transitioned to Molina prior to August 1, 2009. During the transition process, the NetPass enrollees will be given written notification of this change and an opportunity to select another health plan. Sunshine State Health Plan (HMO) has entered into an agreement with Access Health Solutions (FFS PSN) and the Access membership is scheduled to be transitioned to Sunshine prior to September 1, 2009. During the transition process, the Access enrollees will be given written notification of this change and an opportunity to select another health plan.

Table 1 provides a list of all health plan applicants, the date each application was received, the date of application approval and each plan's county of operation, as well as the two pending applications.

Table 1 Health Plan Applicants					
Plan Name	**Plan Type**	**Coverage Area**		**Receipt Date**	**Contract Date**
		Broward	**Duval**		
AMERIGROUP Community Care	HMO	X		04/14/06	06/29/06
Health Ease***	HMO	X	X	04/14/06	06/29/06
Staywell***	HMO	X	X	04/14/06	06/29/06
Preferred Medical Plan	HMO	X		04/14/06	06/29/06
United HealthCare *	HMO	X *	X	04/14/06	06/29/06
Universal Health Care	HMO	X	X	04/17/06	11/28/06
Humana	HMO	X		04/14/06	06/29/06
Access Health Solutions	PSN	X	X	05/09/06	07/21/06
Freedom Health Plan	HMO	X		04/14/06	9/25/07
Total Health Choice	HMO	X		04/14/06	06/07/06
South FL Community Care Network	PSN	X		04/13/06	06/29/06
Buena Vista*	HMO	X *		04/14/06	06/29/06
Vista Health Plan SF*	HMO	X *		04/14/06	06/29/06
Florida NetPASS	PSN	X		04/14/06	06/29/06
Shands Jacksonville Medical Center dba First Coast Advantage	PSN		X	04/17/06	06/29/06
Children's Medical Services, Florida Department of Health	PSN	X	X	04/21/06	11/02/06
Pediatric Associates**	PSN	X **		05/09/06	08/11/06
Better Health	PSN	X	X	05/23/06	12/10/08
Positive Health Care	HMO	X		01/28/08	***Pending***
Medica Health Plans of Florida	HMO	X		09/29/08	***Pending***
Molina Health Plan	HMO	X		12/17/08	03/06/09
Sunshine State Health Plan	HMO	X		1/14/09	05/20/09

* During Fall of 2008, the plan amended its contract to withdraw from this/these counties.

** During Fall of 2008, the plan terminated its contract for this county effective February 1, 2009.

*** During Spring of 2009, the plan notified the Agency of their intent to withdraw from this/these counties.

Table 2 provides a list of the health plan contracts approved by plan name, effective date of the contract, type of plan and coverage area. One new health plan contract was executed since March 2009 (Sunshine State Health Plan, an HMO).

Table 2
Medicaid Reform Health Plan Contracts

Plan Name	Date Effective	Plan Type	Coverage Area		
			Broward	Duval	Baker, Clay, Nassau
AMERIGROUP Community Care	07/01/06	HMO	X		
Health Ease***	07/01/06	HMO	X	X	
Staywell***	07/01/06	HMO	X	X	
Preferred Medical Plan	07/0106	HMO	X		
United HealthCare *	07/01/06	HMO	X *	X	X
Humana	07/01/06	HMO	X		
Access Health Solutions	07/21/06	PSN	X	X	X
Total Health Choice	07/01/06	HMO	X		
South FL Community Care Network	07/01/06	PSN	X		
Buena Vista*	07/01/06	HMO	X *		
Vista Health Plan SF*	07/01/06	HMO	X *		
Florida NetPASS	07/01/06	PSN	X		
Shands Jacksonville Medical Center dba First Coast Advantage	07/01/06	PSN		X	
Pediatric Associates**	08/11/06	PSN	X **		
Children's Medical Services Network, Florida Department of Health	12/01/06	PSN	X	X	
Universal Health Care	12/01/06	HMO	X	X	
Freedom Health Plan	09/25/07	HMO	X		
Better Health Plan	12/10/08	PSN	X		
Molina Health Plan	4/01/09	HMO	X		
Sunshine State Health Plan	06/01/09	HMO	X		

* During Fall of 2008, the plan amended its contract to withdraw from this/these counties.

** During Fall of 2008, the plan terminated its contract for this county effective February 1, 2009.

*** During Spring of 2009, the plan notified the Agency of their intent to withdraw from this/these counties.

Contract Amendments and Model Contracts

There were no general amendments during this quarter. However, five health plans requested and received Agency approval during this quarter to increase their maximum enrollment levels in various counties.

During this quarter, Agency staff continued working on contract revisions for the 2009 consolidated model health plan contract. The consolidated model contract will be a streamlined version of the current model health plan contracts which are now separate models (non-Reform, Reform, FFS PSN, capitated PSN, HMO and Specialty Plan). The Agency is creating one core contract that a health plan will sign with plan type exhibits or riders depending on the unique requirements of the particular plan type (FFS PSN, capitated PSN, HMO, Reform or non-Reform). In June, the draft contract was shared with the health plans, Florida CHAIN, which is a statewide advocacy group, and Florida Legal Services. Feedback from these stakeholders is under review. The Agency intends to use this new model contract for the three-year contract period beginning September 1, 2009.

Contract Conversions/Terminations

Last quarter, two HMOs, HealthEase and Staywell, notified the Agency of their intent to withdraw from the demonstration. Both health plans are owned by parent company Wellcare. Wellcare's stated reasons for pulling out of these counties were not specific to the demonstration but instead were related to the legislated March 1, 2009, capitation rate reduction.

To mitigate the disruption to Staywell and HealthEase enrollees as they enroll with new plans and to assist them through the choice process, the Agency is following a multi-layered approach to ensure proper and timely withdrawal notice to beneficiaries:

- Assessing the capacity of the remaining plans and determining if those plans were able to ensure all impacted beneficiaries have access to quality care.
- Working with the plans and the Choice Counseling vendor to create staggered withdrawal dates to ensure that the volume of beneficiaries being transitioned could occur in an organized manner.
- Working with the plans, the Choice Counseling vendor, local area staff and advocacy groups in ensuring appropriate notice to enrollees.
- Working with the plans to provide primary care provider and service information to ensure continuity of care and minimize disruption to the recipients.

<u>Assessing Capacity</u>

After notification of HealthEase/Staywell withdrawal from the demonstration, the Agency assessed capacity and notified the remaining health plans of the potential enrollments available to their health plans. Several health plans submitted requests to increase their allowed enrollment levels and Agency staff prioritized review of plan provider networks to ensure plans that had the capacity to enroll more members would have the ability to

do so. With the addition of two new health plans in the Broward County area and enrollment level increases for some existing plan, there is more than ample capacity for the remaining health plans to absorb new members.

In an effort to ensure continuity of care, the Agency also undertook a review of the HealthEase and Staywell provider networks to determine the number of HealthEase and Staywell primary care providers (PCPs) that were available in other health plans. The majority of PCPs were currently enrolled in other health plans, thus promoting the enrollees' ability to enroll in plans in which their PCPs were enrolled (76% of HealthEase PCPs are currently enrolled with other health plans and over 86% of Staywell PCPs are currently enrolled with other health plans). The Agency also assisted the PCPs unique to Staywell/HealthEase that were not currently in other health plan networks through the Medicaid provider enrollment process to facilitate their enrollment in other health plan networks.

Staggered Withdrawal

Working with Staywell/HealthEase, in conjunction with the Choice Counseling vendor, the Agency reached an agreement to extend the proposed transition timeline and stagger the HealthEase/Staywell withdrawal to ensure the volume of recipients transitioning would be appropriately managed. The withdrawal schedule is as follows:

HMO	Withdrawal Date	County	Population to Transition
Staywell	May 1, 2009	Duval	@ 2,000
HealthEase	May 1, 2009	Broward	@ 13,000
Staywell	June 1, 2009	Broward	@ 27,000
HealthEase	July 1, 2009	Duval	@ 34,000

The Agency amended its contract with its Choice Counseling vendor to allow for additional counselors to be hired to be properly manage the increased call volume to the Choice Counseling Call Center during the transition period outlined above. In addition, the Choice Counseling vendor stationed Field Choice Counselors in the Medicaid Area Offices in Broward and Duval Counties to assist Staywell/HealthEase enrollees in their choice of a new plan. Field Counselors conducted special face-to-face Choice Counseling sessions specifically geared to transition enrollees, Monday through Friday throughout this quarter. These sessions will continue through July.

To ensure the transition process is properly managed, the Agency is conducting weekly calls with the Medicaid Area Offices and the Choice Counseling vendor to ensure all issues are resolved quickly. The Medicaid Area Offices and the Choice Counseling vendor are tracking the calls related to the Staywell and HealthEase transition to determine how many recipients made a plan choice and how many were assigned per month. In addition, the Field Choice Counselors have begun tracking the following activities:

- Number of on-site sessions.

- Number of telephone referrals to Field Choice Counselor.
- Number of enrollments completed by Field Choice Counselors as a result of Face to Face or Phone referrals.
- Number of plan changes completed by Field Choice Counselors as a result of Face to Face or Phone referrals.

Enrollee and Provider Notice

During the third quarter of Year Three, all beneficiaries and providers impacted by the Staywell and HealthEase withdrawal were provided written notification of this change in compliance with state and federal regulations. The Agency took additional measures outlined below to ensure that beneficiaries were well informed of the special enrollment sessions established to assist them in making appropriate health plan choices.

- On April 27, the Agency sent the second set of 30-day notices to Staywell and HealthEase enrollees stating the plan they will be assigned to (effective June 1, 2009) if they do not choose a plan within the next 30 days.
- On May 29, 2009, the Agency sent the third set of 30-day notices to Staywell and HealthEase enrollees stating the plan they will be assigned to (effective July 1, 2009) if they do not choose a plan within the next 30 days.
- The Agency worked with its Choice Counseling vendor, the health plans and various advocacy groups to ensure the transition message being communicated would be easy to understand and available through many forums. The Agency developed flyers to be released to advocacy groups, the Florida Department of Health, large Staywell/HealthEase providers, shelters for the homeless, homeless meal locations, as well as the Florida Department of Children and Families to help ensure recipients understood the changes that were occurring. In addition, Medicaid Area Office staff researched HIV service providers/case worker locations to include them in the outreach activities.

Transition information, including the flyers, was also available on the Choice Counseling website. The wording used in the flyer was revised to incorporate comments received from Florida CHAIN and Florida Legal Services. Input and assistance from these advocacy groups continues to be helpful in the Agency's efforts to ensure beneficiaries are well informed. The Agency worked with the Florida Department of Children and Families to distribute information on the transition to staff who determine Medicaid eligibility.

Minimizing Disruption to Affected Enrollees

In order to minimize disruption of care, the Agency requested PCP information and special needs information from Staywell/HealthEase. Once Staywell/HealthEase members were transitioned to new plans, the Agency supplied the PCP information and special needs information to the new health plan.

Additionally, the health plan contracts specifically provide for appropriate transition of care when a new enrollee joins a plan. This protection ensures that beneficiaries will

continue to receive services through current providers until a new plan of care can be authorized.

FFS PSN Conversion Process

Pursuant to the 2009 Legislation which revised section 409.91211(3)(e), F.S., FFS PSNs must convert to capitation no later than the beginning of the sixth year of operation (previously, the statute stated no later than the beginning of the fourth year of operation). This change will require most of the current PSNs to enter into a capitated health plan contract with a service date of September 1, 2011, unless the PSN opts to convert to capitation earlier. The Agency continues to provide technical assistance to the PSNs regarding conversion. In addition, the Agency continues its internal review to ensure that conversion issues related to FFS claims processing will be appropriately discussed and resolved.

Table 3 provides the list of required capitation go-live dates for the current FFS PSN contractors.

Table 3
PSN Conversion to Capitation Implementation Dates

FFS PSN Name	Scheduled Capitation Implementation Date
Access Health Solutions	09/01/2011
Better Health	05/01/2014
Children's Medical Services Network, Florida Department of Health	12/01/2011
Shands Jacksonville Medical Center dba First Coast Advantage	09/01/2011
South Florida Community Care Network	09/01/2011

While most FFS PSNs have submitted conversion workplans and applications to the Agency in order to comply with the previous 3-year conversion-to-capitation requirement, the Agency expects that many PSNs will change their conversion applications to allow them to learn from the additional two years of experience. Table 4 provides the timeline for each step in this conversion process based on the current contract. However, the draft contract that will go into effect on September 1, 2009, contract extends the FFS PSNs deadline for submission of the conversion work plan to 24 months after beginning operations and extends the deadline for submission of the conversion application to August 1 of the fourth year of operations.

Table 4
PSN Conversion to Capitation Timeline

Deadline for the FFS PSN to submit its conversion workplan to the Agency	01/31/2010
Deadline for the FFS PSN to submit its conversion application to the Agency	12/31/2010
Successful conversion applicants and the Agency to execute capitated contracts for service begin date of 09/01/2011	06/30/2011

FFS PSN Reconciliations

During this quarter, the Agency continued work on two reconciliation[1] periods: one period for the first four months of the second contract year (September 2007 through December 2007) and the final reconciliation for the first contract year (September 2006 through August 2007). The Agency continues to provide technical assistance to PSNs that have requested additional time as they analyze their reconciliation data.

Systems Enhancements

With the conversion to the new Medicaid Fiscal Agent, new systems changes continue to occur and continued technical assistance is being provided for HMOs and PSNs during Demonstration Year Three (see Section K of this report under the heading: FFS PSN Systems Monthly Conference Calls). As the new system becomes fully operational, the Agency will continue to work with PSN stakeholders to initiate systems changes to make claims processing easier for PSN providers. These system changes will allow PSNs to be more innovative in their health care delivery and achieve efficiencies not currently available.

[1] Reconciliation is the process by which the Agency compares the per member per month (PMPM) cost of FFS PSN enrollees against what the Agency would have paid the FFS PSN had the PSN been capitated in order to determine savings or cost effectiveness. The FFS PSNs are expected to be cost effective and the Agency reconciles payment to them periodically according to contract requirements.

2. Benefit Package

Overview

Customized benefit packages are one of the fundamental elements of the demonstration. Medicaid beneficiaries are offered choices in health plan benefit packages customized to provide services that better suit health plan enrollees' needs. The 1115 Medicaid Reform Waiver authorizes the Agency to allow capitated plans to create a customized benefit package by varying certain services for non-pregnant adults, varying cost-sharing, and providing additional services. PSNs that chose a FFS reimbursement payment methodology could not develop a customized benefit package, but could eliminate or reduce the co-payments and offer additional services.

To ensure that the services were sufficient to meet the needs of the target population, the Agency evaluated the benefit packages to ensure that they were actuarially equivalent and sufficient coverage was provided for all services. To develop the actuarial and sufficiency benchmarks, the Agency defined the target populations as Family and Children, Aged and Disabled, Children with Chronic Conditions, and Individuals with HIV/AIDS. The Agency then developed the sufficiency threshold for specified services. The Agency identified all services covered by the plans and classified them into three broad categories: covered at the State Plan limits, covered at the sufficiency threshold, and flexible. For services classified as "covered at the State Plan limit," the plan did not have flexibility in varying the amount, duration or scope of services. For services classified under the category of "covered at the sufficiency threshold," the plan could vary the service so long as it met a pre-established limit for coverage based on historical use by a target population. For services classified as "flexible," the plan had to provide some coverage for the service, but had the ability to vary the amount, duration, and scope of the service.

The Agency worked with an actuarial firm to create data books of the historic FFS utilization data for all targeted populations for Year One, Year Two, and Year Three of the demonstration. Interested parties were notified that the data book would be emailed to requesting entities. This information assisted prospective plans to quickly identify the specific coverage limits required to meet a specific threshold.

All health plans are required to submit their customized benefit packages annually to the Agency for verification of actuarial equivalence and sufficiency. The Agency posted the first online version of a Plan Evaluation Tool (PET) in May 2006. The PET allows a plan to obtain a preliminary determination as to whether or not it would meet the Agency's actuarial equivalency and sufficiency tests before submitting a benefit package. The Agency released the first data book on March 22, 2006. Subsequent updates to the data book were released on May 23, 2007 for Year Two and May 7, 2008 for Year Three. The design of the PET and the sufficiency thresholds used in the PET remained unchanged from the previous years. The annual process of verifying the actuarial equivalency and sufficiency test standards, and the tool (PET) is typically completed during the last quarter of each state fiscal year. The verification process included a

complete review of the actuarial equivalency and sufficiency test standards, and catastrophic coverage level based upon the most recent historical FFS utilization data.

The health plans have become innovative about expanding services to attract new enrollees and to benefit enrollees by broadening the spectrum of services. The standard Florida Medicaid State Plan package is no longer considered the perfect fit for every Medicaid beneficiary, and the beneficiaries are getting new opportunities to engage in decision-making responsibilities relating to their personal health care.

The Agency, the health plans and the beneficiaries can see the value of customization. The Agency has seen an increase in the percentage of voluntary plan choices. The health plans have used the opportunity to offer additional, alternative and attractive services. In addition, the health plan enrollees are receiving additional services that were not available under the regular Florida Medicaid State Plan. The average value of the customized benefits package continues to exceed the Florida Medicaid State Plan benefit package in Year Three of the demonstration.

Current Activities

The benefit packages customized by the health plans for Demonstration Year Three became operational on November 1, 2008, and will remain valid until August 31, 2009. These benefit packages include 28 customized benefit packages for the HMOs and 14 different expanded benefits for the FFS PSNs.

The 12 HMOs offering customized benefit packages for TANF and SSI targeted populations during Year Three of the demonstration are Amerigroup, Buena Vista, Freedom Health Plan, HealthEase, Humana, Molina Healthcare, Preferred Medical Plan, StayWell, Total Health Choice, United Health Care, Universal Health Care, and Vista South Florida. The 7 FFS PSNs are Access Health Solutions, Better Health, Children's Medical Services, First Coast Advantage, NetPass, Pediatric Associates, and the South Florida Community Care Network.

One of the significant changes in the benefit packages for Year Three is the increase in the total number of copayments from Demonstration Year Two. In total, there are 85 more copayments required during Year Three (104) than in Year Two (19). From Year Two to Year Three, there were increases in the number of copayments in all categories except dental. However, despite the increase in the number of copayments, 20 benefit packages (71%) have no copayments in all 16 categories. Please note that copayments only apply to non-pregnant adults.

During the third quarter of Year Three, Buena Vista, Vista South Florida, and Pediatric Associates ceased operations within the demonstration counties. The beneficiaries who had been enrolled in these health plans were transitioned into the remaining plans. The departure of these plans, specifically the two Vista health plans, greatly changes the values regarding required copayments reported in Tables 5, 6 and 7. The Vista health plans required copayments, one for every type of service, and as a result of their departure the total number of copayments required has decreased from 104 to 40. In

addition, the percentage of benefit packages requiring no copayments has increased to 83% (see Table 5 and 6).

Table 5 lists the number of copayments for each service type by each demonstration year. Year Three has been divided into 2 columns (July 1, 2008 to December 31, 2008 and January 1, 2009 to June 30, 2009) to reflect the departure of the plans which ceased operations during the third quarter.

Table 6 indicates the number and percentage of each benefit package which in total does not require any copayments, also shown by demonstration year. Table 7 shows that for each area and target population there are at least 2 benefit packages to choose from with no copayments.

Table 5
Number of Copayments by Type of Service by Demonstration Year

Type of Service	Year One	Year Two	Year Three (July-Dec)	Year Three (Jan-June)
Chiropractic	10	0	8	4
Hospital Inpatient: Behavioral Health	11	1	8	4
Hospital Inpatient: Physical Health	7	1	8	4
Podiatrist	10	0	7	3
Hospital Outpatient Services (Non-Emergency)	7	1	7	3
Hospital Outpatient Surgery	7	1	8	4
Mental Health	7	3	6	2
Home Health	4	1	8	4
Lab/X-Ray	5	1	7	3
Dental	4	4	4	0
Vision	4	0	5	1
Primary Care Physician	0	0	5	1
Specialty Physician	1	1	6	2
ARNP / Physician Assistant	0	0	5	1
Clinic (FQHC, RHC)	0	0	6	2
Transportation	5	5	6	2
Total Number of Required Copayments	**82**	**19**	**104**	**40**

Table 6
Number & Percent of Total Benefit Packages Requiring No Copayments By Demonstration Year

	Year One	Year Two	Year Three (July-Dec)	Year Three (Jan-June)
Total Number of Benefit Packages	**28**	**30**	**28**	**24**
Total Number of Benefit Packages Requiring No Copayments	**12**	**16**	**20**	**20**
Percent of Benefit Packages Requiring No Copayments	**43%**	**53%**	**71%**	**83%**

Table 7
Number of Benefit Packages Requiring No Copayments
By Target Population & Area
4th Quarter of Demonstration Year Three

Target Population	List of Counties in Each Demonstration Area	Number of Benefit Packages Not Requiring Copayments
SSI (Aged and Disabled)	Duval, Baker, Clay and Nassau	4
SSI (Aged and Disabled)	Broward	8
TANF (Children and Families)	Duval, Baker, Clay and Nassau	2
TANF (Children and Families)	Broward	6

In Year Three of the demonstration, many plans continue to provide services not currently covered by Medicaid to attract enrollees. In the health plan contract, these are referred to as expanded services. There are 11 different expanded services offered by the health plans during this contract year. The 2 most popular expanded services offered were the same as Year Two: the over-the-counter (OTC) drug benefits and the adult preventative dental benefits. Thirteen of the customized benefit packages decreased their OTC value, while one added a $25 OTC benefit. The expanded services available to beneficiaries include:

- Over-the-counter drug benefit from $20 to $25 per household, per month;
- Adult Preventative Dental;
- Circumcisions for male newborns;
- Acupuncture;
- Additional Adult Vision - up to $125 per year for upgrades such as scratch resistant lenses;
- Additional Hearing – up to $500 per year for upgrades to digital, canal hearing aid;
- Respite care; and
- Nutrition Therapy.

Since implementation of the demonstration, no changes have been made to the sufficiency thresholds that were established for the first contract period of September 1, 2006 to August 31, 2007. After reviewing the available data – including data related to the plans' pharmacy benefit limits – the Agency decided to limit the pharmacy benefit in Year Three to a monthly script limit only. In Demonstration Year One and Year Two, plans had the option of having a monthly script limit or a dollar limit on the pharmacy benefit. This change was made to standardize the mechanism used to limit the pharmacy benefit. The Agency will continue to require the plans to maintain the current sufficiency threshold level of pharmacy benefit for SSI and TANF at 98.5 percent.

The Agency continues to review utilization and other data to establish options for allowing more customization and more flexibility in both Medicaid covered services and

expanded services in the next operational years. Since the health plans can manage enrollee health care through utilization management and case management expertise, plans are better able to offer resources to provide care that is better suited to individual members. Examples of benefits that are more valued by beneficiaries are individualized alternative treatment and additional benefits that are not covered under state plan services.

The PET submission procedure for Demonstration Year Three was similar to that of the two previous years. The updated version of the data book was released by the Agency on May 7, 2008, and the new PET was made available to the health plans on May 23, 2008. However, the deadline for the health plans to submit their updated PETs was extended to August 13, 2008, due to the release of the draft rates on August 8, 2008. This extension required the effective date of the Year Three benefit packages to be revised to November 1, 2008. This revision was made in order to provide adequate notification to the beneficiaries of any reduction in their current health plan's benefit package, as well as to allow time for the printing and distribution of the revised choice materials, which included the plan benefit packages for Year Three of the demonstration.

The PET submission procedure for Year Four will be similar to Year Three. The data book and the PET is scheduled to be made available to the health plans in August 2009 and the health plans' Year Four benefit packages will have an effective date of November 1, 2009.

3. Grievance Process

Overview

The grievance and appeals process specified in the demonstration health plan contracts was modeled after the existing managed care contractual process and includes a grievance process, appeal process, and Medicaid Fair Hearing (MFH) system. In addition, plan contracts include timeframes for submission, plan response and resolution of beneficiary grievances. This is compliant with Federal grievance system requirements located in Subpart F of 42 CFR 438. The health plan contracts also include a provision for the submission of unresolved grievances, upon completion of the health plan's internal grievance process, to the Subscriber Assistance Panel (SAP) for the licensed HMOs, prepaid health clinics, and exclusive provider organizations; and to the Beneficiary Assistance Panel for enrollees in a FFS PSN (as described on the following page). This provides an additional level of appeal.

As defined in the health plan contracts:

- Action means the denial or limited authorization of a requested service, including the type or level of service, pursuant to 42 CFR 438.400(b); the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the State; the failure of the Health Plan to act within ninety (90) days from the date the Health Plan receives a Grievance, or 45 days from the date the Health Plan

receives an Appeal; and for a resident of a rural area with only one (1) managed care entity, the denial of an Enrollee's request to exercise his or her rights to obtain services outside the network.

- Appeal means a request for review of an Action, pursuant to 42 CFR 438.400(b).
- Grievance means an expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

Under the demonstration, the Legislature required that the Agency develop a process similar to the SAP as enrollees in a FFS PSN do not have access to the SAP. In accordance with Section 409.91211(3)(q), F.S., the Agency developed the Beneficiary Assistance Panel (BAP), which is similar in structure and process to the SAP. The BAP will review grievances within the following timeframes (same timeframes as SAP):

1. The state panel will review general grievances within 120 days.
2. The state panel will review grievances that the state determines pose an immediate and serious threat to an enrollee's health within 45 days.
3. The state panel will review grievances that the state determines relate to imminent and emergent jeopardy to the life of the enrollee within 24 hours.

Enrollees in a health plan may file a request for a Medicaid fair hearing at any time and are not required to exhaust the plan's internal appeal process or the SAP or BAP prior to seeking a fair hearing.

Current Activities

In an effort to improve the demonstration, the Agency recognizes the need to understand the nature of all issues, regardless of the level at which they are resolved. In an attempt to better understand the issues beneficiaries face and how and where they are being resolved, the Agency is reporting all grievances and appeals at the health plan level in our quarterly reports. The Agency also uses this information internally, as part of the Agency's continuous improvement efforts.

Grievances & Appeals

Table 8 provides the number of grievances and appeals by health plan type for the previous quarter ending March 31, 2009. The health plan grievance and appeals reporting cycle coincides with the due date for this quarterly report. To allow for review of the data received and to report as accurately as possible, the grievances and appeals report will lag one quarter in each quarterly report and will be updated in the annual report to reflect the full year of data.

Table 8 Grievances and Appeals *January 1, 2009- March 31, 2009*					
	PSN Grievances	**PSN Appeals**	**HMO Grievances**	**HMO Appeals**	**HMO & PSN Enrollment***
Total	54	9	170	85	236,375

*unduplicated enrollment count

Medicaid Fair Hearings

Table 9 provides the number of MFH requested during the quarter ending June 30, 2009. Medicaid Fair Hearings are conducted through the Florida Department of Children and Families and as a result, health plans are not required to report the number of fair hearings requested by enrolled members. However, the Agency monitors the Medicaid Fair Hearing process. Of the 6 MFH requests, all were related to denial of benefits/services, with two outcomes favorable to the HMO, two hearings were withdrawn and therefore favorable to the beneficiary, and two hearings are being rescheduled.

Table 9 Medicaid Fair Hearing Requests *April 1, 2009 – June 30, 2009*	
PSN	3
HMO	3

BAP & SAP

Health plans appear to be successfully resolving grievances and appeals at the plan level as only 3 grievances have been submitted to the SAP and none to the BAP for this quarter. Of the three SAP requests; two were withdrawn and one is pending.

Table 10 provides the number requests to BAP and SAP for the quarter ending June 30, 2009.

Table 10 BAP and SAP Requests *April 1, 2009 – June 30, 2009*	
BAP	0
SAP	3

4. Complaint/Issue Resolution Process

Complaints/issues received by the Agency regarding the health plans provide the Agency with feedback on what is working and not working in managed care under the demonstration. Complaints/issues come to the Agency from beneficiaries, advocates, providers and other stakeholders and through a variety of Agency locations. The primary locations where the complaints are received by the Agency are as follows:

- Medicaid Local Area Offices,
- Medicaid Headquarters Bureau of Managed Health Care,
- Medicaid Headquarters Bureau of Health Systems Development, and
- Medicaid Choice Counseling Helpline. Health plan complaints received by the Choice Counseling Helpline are referred to the Florida Medicaid headquarters offices specified above for resolution.

The complaints/issues are worked by Medicaid Local Area Office and/or Headquarters staff depending on the nature and complexity of the complaint/issue. Some complaints/issues are referred to the health plan for resolution and the Agency tracks these to ensure resolution. This tracking is accomplished through a consolidated automated database, implemented October 1, 2007, that is used by all Agency staff housed in the above locations to track and trend complaints/issues received.

The Agency tracks complaints by plan and plan type (PSN and HMO) and continues to review particular complaint data on individual plans on a monthly basis and reviews complaint trends on a quarterly basis at the management level.

This quarter, the Agency received six complaints/issues related to FFS PSNs and received 58 complaints/issues related to HMOs, for a total of 64 complaints. The complaints/issues received during this quarter are provided in Attachments I (PSN) and II (HMO). Attachment I provides the details on the complaints/issues related to FFS PSNs and outlines the action(s) taken by the Agency and/or the PSNs to address the issues raised. Attachment II provides the details on complaints/issues related to the HMOs and outlines the action(s) taken by the Agency and/or the HMOs to address the issues raised.

During this quarter, five of the PSN complaints/issues were from members and one was from a provider. Member issues included needing assistance in accessing providers and assistance with ending balance billing. The one provider issue was regarding providing continuity of care for a member changing from one plan to another.

The majority of the HMO complaints/issues this quarter were related to member issues, with the majority being related to members needing assistance with finding/seeing a provider and getting authorization for services. Other member issues included needing assistance in getting enhanced benefit credits and members being mistakenly billed or balance-billed. Provider issues included payment delays/denials. The Agency

continues to monitor enrollment complaint issues related to enrollment data provided to the health plans by the Fiscal Agent.

The Agency's staff worked directly with the members and with the HMOs and PSNs to resolve issues. For both PSN and HMO issues, education was provided to members and to providers to assist them in obtaining the requested information/service and for future use. The HMOs and PSNs were informed of all the member issues, and in most cases, the HMOs and PSNs were instrumental in obtaining the information or service needed by the member or provider.

Agency staff will continue to resolve complaints in a timely manner and to monitor the complaints received for contractual compliance, plan performance, and trends that may reflect policy changes or operational changes needed.

5. On-Site Surveys

During this quarter, the Agency conducted focused reviews at one HMO and one PSN. The HMO had a utilization management review of its prior authorization system, including a review of its policies and procedures and interviews with plan staff. The PSN had medical record, disease management and case management record reviews, which included a review of policies and procedures and interviews with plan staff. Additional reviews will be conducted by the Agency next quarter.

Table 11 provides the list of on-site survey categories.

Table 11 **On-Site Survey Categories**
➲ Services
➲ Marketing
➲ Utilization Management
➲ Quality of Care
➲ Provider Selection
➲ Provider Coverage
➲ Provider Records
➲ Claims Process
➲ Grievances & Appeals
➲ Financials

The Agency continues to work with the EQRO, Health Services Advisory Group, Inc. (HSAG), on refining our survey instrument. HSAG has also reviewed one plan's quality improvement process, which showed the plan was in compliance; however some changes and additions to the plans quality improvement process were needed. The report will be included in the HSAG's year-end report to the Agency.

B. Choice Counseling Program

Overview

The demonstration is in its fourth quarter of Year Three. A continual goal of the demonstration is to empower beneficiaries to take control and responsibility for their own health care by providing them with the information they need to make the most informed decisions about health plan choices. Choice Counseling continues to look for ways to reach the beneficiaries and offer services to help them make an informed choice.

The Preferred Drug List (PDL) search functionality called the Informed Health Navigator Solution (Navigator) was implemented in the 2nd quarter of demonstration Year Three and use of the system by beneficiaries continues to grow, as outlined in the Informed Health Navigator Solution section of this report.

The Field Choice Counselors continue their efforts to reach out and provide support to beneficiaries that access mental health services through their Mental Health Unit (MHU). The MHU (comprised of three Choice Counselors) held several presentations with community partners that offer mental health and substance abuse services. The MHU was especially helpful in assisting beneficiaries during the transition of Staywell and Healthease members. Additional information on the MHU activities is provided in the Outreach/Field portion of this report.

As outlined in Section A of this report, Staywell and Healthease transition out of the demonstration counties concluded effective July 1, 2009. Several actions were taken during this transition to respond to increased call volume, including weekly transition meetings between Agency staff and the Choice Counseling Program staff. These meetings began in February 2009 and continued for the duration of the transition. Activities undertaken by the Agency, health plans, and Choice Counseling to address the Staywell / Healthease transition are outlined in Section A. Highlights of the efforts undertaken by Choice Counseling Program to address the Staywell / Healthease transition are summarized below. Some efforts remained in place past the conclusion of the transition, to address any residual questions or concerns.

- Field Choice Counselors were and will continue to be available (by phone or in person) daily at the Medicaid Area Offices through the end of July 2009. The counselors provide information about plan choices and enroll the beneficiaries in the plan of his or her choice. (Ends effective 08/01/09)
- Training provided to Medicaid Area Office staff on enrolling beneficiaries in a plan of their choice. (Ends effective 09/01/09)
- Increased staff to address the increase in the call volume. (Ends effective 08/01/09)
- Staggered the mailing of notices to beneficiaries about the upcoming Staywell and Healthease transition to manage the increased call volume. (One time process)

- Field Choice Counselors reached out to community partners and sister agencies to inform them about the transition and offer ways to get help for beneficiaries. (Normal operational process)
- Created and distributed, with input from stakeholders, posters/flyers to inform beneficiaries about the transition. The poster/flyer was made available to the Medicaid Area Offices and Field Choice Counselors for distribution and posting at key locations. (One time process)
- Modified the Automated Voice Response System (AVRS), to identify and more quickly route transition related callers to a specialized Choice Counselor group. (Ends effective 09/01/09)

The new Fiscal Agent system was implemented in July 2008. This transition continues to impact the Choice Counseling Program. The Enrollment Broker/Choice Counselor, Affiliated Computer Services (ACS), receives its newly eligible information, enrollment, and all data from the new Fiscal Agent, Electronic Data Systems (EDS). The Agency, ACS and EDS continue to work together to ensure the transfer of correct and timely information from the Fiscal Agent to ACS. Continued improvements were made over the last quarter as more issues have been identified and resolved. Receiving accurate data from the new Fiscal Agent is key for ACS to be able to meet contract standards for enrollment, call statistics, and mailroom standards, etc. ACS and EDS continue to demonstrate the ability to problem solve and made great efforts to work together along with the Agency to resolve these issues.

The Agency and ACS continue to work together to ensure beneficiary's needs are addressed in a timely manner with actions such as:

- Authorizing the Choice Counseling Call Center and Field Choice Counselors to allow Good Cause plan changes when a beneficiary has had any difficulty accessing choice counseling services or the information in the Choice Counseling System has been incorrect;
- Requesting the Field Choice Counselors reach out to community partners to help communicate with beneficiaries;
- Requiring the Field Choice Counselors to handle Choice Counselor Call Center call backs (from messages taken), and manage an increased amount of plan changes;
- Continuing the use of the Mental Health Unit to address questions specific to mental health; and
- Using Special Needs Unit Nurses to reach out and help those that have complex health needs.

These efforts along with others mentioned in this section are helping beneficiaries remain satisfied with their overall Choice Counseling experience.

Beneficiary satisfaction levels with the Choice Counseling Program are monitored through the Customer Service Survey, which continues to be utilized by the beneficiary. The Agency and ACS are closely monitoring beneficiary responses. The beneficiary's experience and feedback is very important especially during this transition time, and

their responses continue to be positive (see Table 13 for survey results). The positive Customer Service Survey responses received speak very highly about the efforts being made by the Choice Counselors.

Current Activities

1. Informed Health Navigator Solution (Navigator)

Navigator is a Preferred Drug List (PDL) search system, and was implemented in October of 2008. The Navigator function allows the Choice Counselor to provide basic information to the beneficiaries on how well each plan meets his or her prescribed drug needs. This additional information is provided to assist the beneficiary in making a plan selection. The Navigator system contains each health plan's PDL and prescribed drug claims data. For any beneficiary who has had prior Medicaid prescribed drug claims data (either fee-for-service or managed care), Navigator pulls the prescription data and provides detailed information on how each plan meets the beneficiary's current prescribed drug needs. This detail allows the counselor to provide more information to the beneficiary and does not require that the individual remember his or her current medications. The Navigator system also has the capability for a Choice Counselor to input prescribed drugs for beneficiaries who do not have prior claims history or have received a new prescription not yet in their records. This function allows the Choice Counselor to provide basic information to the beneficiaries on how well each plan meets their prescribed drug needs. The Choice Counselor's role is to share the Navigator search results of the plan's PDL and not to counsel a beneficiary regarding particular medications.

Table 12 provides the Navigator statistics from April1 through June 30, 2009. "Sessions" represents the number of times the Navigator program was utilized, and "Recipients" represents the number of unique individuals. An individual can ask about additional medication information for themselves and it would be considered a single session. If that same individual asked for information for their child (different ID number), that would be considered a separate session and recipient.

Since the "Go Live" date of October 27, 2008, through June 30, 2009, for the Navigator, there have been a total of 4,668 sessions and 3,583 unique recipients that have utilized the system.

Table 12
Navigator Statistics
(April 1, 2009 through June 30, 2009)

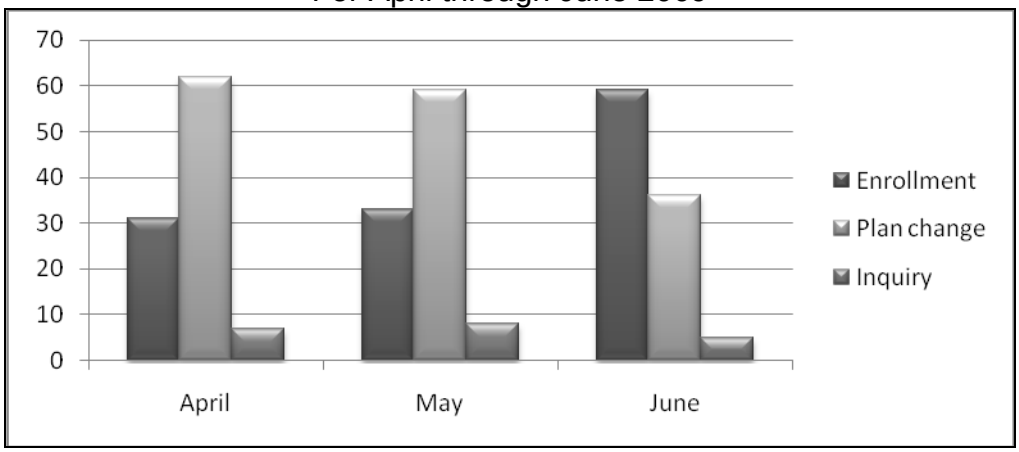
Week	Sessions	Recipients
04/01 - 04/04	100	83
04/05 - 04/11	129	116
04/12 - 04/18	167	140
04/19 - 04/25	150	117
04/26 - 05/02	151	122
05/03 - 05/09	125	104
05/10 - 05/16	129	110

Table 12 Navigator Statistics (April 1, 2009 through June 30, 2009)		
05/17 - 05/23	101	71
05/24 - 05/30	131	108
05/31 - 06/06	127	101
06/07 - 06/13	164	136
06/14 - 06/20	137	115
06/21 - 06/27	120	104
06/28 - 06/30	75	52

The quarterly totals for the Navigator were 1,806 sessions and 1,479 unique recipients utilized the system.

Beginning the previous quarter, Choice Counseling started capturing data to indicate whether a person was using the Navigator for an enrollment, plan change, or an inquiry. Figure A shows (by percentages) what types of calls were received using this program as a choice driver over the quarter (listed per month). There were a significant number of beneficiaries that utilized Navigator to make plan changes during April and May 2009. The increased usage by beneficiaries to make plan changes was attributed to Staywell and Healthease transition. In June 2009, enrollments were again the highest type of call using the navigator.

Chart A
Informed Navigator Use by Call Type
For April through June 2009



Beneficiary Customer Survey

Every beneficiary who calls the toll-free Choice Counseling number is provided the opportunity to complete a survey at the end of the call. The Call Center does have a set day of the week when the Choice Counselors offer the survey to callers, this helps to reach the goal of at least 400 completed surveys each month. During the months of April 2009 through June 2009, 1,352 beneficiaries completed the automated survey.

The Customer Survey ratings consider 100% to be a perfect score, with a scoring range of 1 being lowest and 9 being highest. 100% or 9 reflects a truly satisfied caller. The scoring range translates into the following percentages:

1 = 00.00%
2 = 12.50%
3 = 25.00%
4 = 37.50%
5 = 50.00%
6 = 62.50%
7 = 75.00%
8 = 87.50%
9 = 100%

As stated above, the survey provides for a caller to rank their experience in all areas of the call on a scale from 1 through 9. If a recipient scores a category between 1 and 3, the caller has the ability to leave a comment about why they left a low score. The caller also has the ability to request a supervisor call back so the beneficiary can provide even more feedback on his or her experience.

During this quarter, the overall beneficiary survey scores remained high. The scores for the amount of time the beneficiary had to "wait on hold" continued to decline. The reduction in the score for the hold time began in August 2008, and correlates with the increased number of incoming calls to the Call Center due to issues with the new Fiscal Agent. This quarter the increased calls is also associated with the recent Staywell and Healthease transition.

ACS utilized the "red alert" messaging system as an immediate response to offset the caller's wait time (as reported in the next section of the report). This action helped beneficiaries get the responses they needed in a shorter amount of time, as auxiliary staff responded to messages during non-peak times.

Table 13 shows how the beneficiaries scored their experience with the Choice Counseling Call Center (represented in percentages) from April through June of 2009. The number of beneficiaries participating in the Survey this quarter was as follows: April - 434, May - 446, and June - 472 (totaling 1,352).

The top three survey categories for the quarter were: "Being treated respectfully", "Ability to explain clearly" and "Overall service provided by counselor". The three lowest scoring survey categories were: "Amount of time waiting to speak with a Choice Counselor", "How easy was it to understand information received" and "How helpful do you find this counseling to be".

Table 13 Choice Counseling Survey Results Percentage of Delighted Callers Per Question		
April	**May**	**June**
How helpful do you find this counseling to be		
86.60%	83.60%	88.60%
Amount of time you waited		
29.30%	23.10%	39.40%
Ease of understanding info		
79.60%	72.20%	76.50%
Likelihood to recommend		
87.10%	84.80%	91.90%
Overall service provided by Counselor		
94.70%	94%	96.80%
Quickly understood reason		
95.20%	93.90%	96.20%
Ability to help choose plan		
94.20%	93.50%	95.60%
Ability to explain clearly		
94.00%	95.10%	96.60%
Confidence in the information		
91.20%	92.80%	95.30%
Being treated respectfully		
97.50%	96.20%	98.50%

2. Call Center

The Choice Counseling Call Center, located in Tallahassee, Florida, operates a toll-free number and a separate toll-free number for the hearing-impaired callers. The Call Center uses a tele-interpreter language line to assist with calls in over 100 languages. The hours of operation are Monday through Thursday 8:00 a.m. – 8:00 p.m. and Friday 8:00 a.m. -7:00 p.m., providing no Saturday hours. The Call Center had an average of 42 full time equivalent (FTE) employees who speak English, Spanish, and Haitian Creole to answer calls.

The Call Center has reported a continually growing volume of incoming calls. June 2009 was the month with the highest call volume, with 33,250 calls received. The Agency and ACS have been in continual communication about the call volume and ACS has worked very diligently to handle this increase in volume with both short and long term solutions.

- The “red alert” messaging system has been continued to give beneficiaries the opportunity to leave a message after 5 minutes of hold time. Callbacks to these beneficiaries happen within 48 hours. This is a short-term solution and will continue as needed to manage the call volume and wait time to reach a counselor.

- The Call Back Manager (CBM) remains a long-term solution to give the beneficiaries an alternative to physically waiting on the line. This feature allows beneficiaries to reserve their place in the call queue, without having to actually remain on the phone. The beneficiary receives an automatic return call when they are next in “line”. The beneficiary may also designate a future date and time to receive a return call. When the specified date and time arrive, the system dials them and places them with the next available counselor. This feature is offered to the beneficiaries 20 seconds after making their initial options selection and approximately every 45 seconds thereafter.

In addition, the Agency continues to work closely with ACS to ensure the Call Center is sufficiently staffed. The number of Choice Counselors peaked at 50 in June 2009. The significant increase in staffing at the Call Center that occurred this quarter was needed to handle the increased call volume related to the Staywell and Healthease transition.

Table 14 compares the call volume of incoming and outgoing calls during the fourth quarter of Demonstration Year Two and Year Three.

Table 14
Comparison of Call Volume for 4th Quarter
(Year Two & Year Three)

Type of Calls	Apr 2008	Apr 2009	May 2008	May 2009	Jun 2008	June 2009	Year 2 4th Quarter Totals	Year 3 4th Quarter Totals
Incoming Calls	15,914	25,206	14,850	24,163	14,738	33,250	**45,502**	**82,619**
Outgoing Calls	4,780	3,963	4,757	3,090	3,301	6,016	**12,838**	**13,069**
Totals	20,694	29,169	19,607	27,253	18,039	39,266	**58,340**	**95,688**

The Choice Counseling Program met and exceeded the contract standards in the Call Center during the first two years of the demonstration. The statistics in Table 14 show the dramatic increase of calls in the fourth quarter of demonstration Year Three. There were 37,117 more incoming calls than were reported in the fourth quarter of Year Two. In June 2009, the incoming call volume increased by 126% compared to the incoming call volume a year ago. (The incoming call volume was 14,738 in June 2008; and the incoming call volume was 33,250 in June 2009). The outgoing calls have changed their focus to be return calls rather than outbound phone list contacts since the “red alert” system was added.

3. Mail

Outbound Mail

During the quarter, the ACS mailroom mailed the following:

New-Eligible Packets (mandatory and voluntary)	27,222
Auto-Assignment Letters	48,966
Confirmation Letters	35,668
Open Enrollment Packets	18,151
Transition Packets	634
Plan Transfer Letters (mandatory and voluntary)	6,176

During this quarter, a new letter for health plan transfers was mailed to those recipients who were in Broward County in NetPass health plan. There were two different letters sent depending on whether the beneficiary is mandatory or voluntary for managed care. The number of letters above reflect both the mandatory and voluntary letters together.

The amount of returned mail has increased this quarter. The increase is attributed to the increased mailing associated with Staywell and Healthease transition, but is still within 3-5% range estimated for return mail. When returned mail is received, the Choice Counseling staff access the ACS enrollment system and the State's Medicaid system to try to locate a telephone number or a new address in order to contact the beneficiary. The Outreach Team is a big help with this effort in contacting beneficiaries. The Choice Counseling staff work to re-address the packets or letters when possible, with the newly eligible mailings taking top priority.

Inbound Mail:

During the quarter, ACS processed the following:

Plan Enrollments	2,643
Plan Changes	397

The percentage of enrollments processed through the mail-in enrollment forms has remained 2-5% of total enrollments. The Agency and ACS are reviewing the enrollment form to make it easier to complete properly and change the mail-in process to make it easier for beneficiaries with the goal of increasing utilization of this enrollment option. The other consideration is that the mail-in enrollment option is not viable and ACS could increase services in another area of the program to better serve beneficiaries if this option is discontinued.

4. Face-to-Face/Outreach and Education

During the quarter, the Field Choice Counseling Outreach Team continued to reach those beneficiaries that were transitioning out of Staywell and Healthease. The comparison of the Field activities for the third and fouth quarters of demonstration Year Three are provided in Table 15:

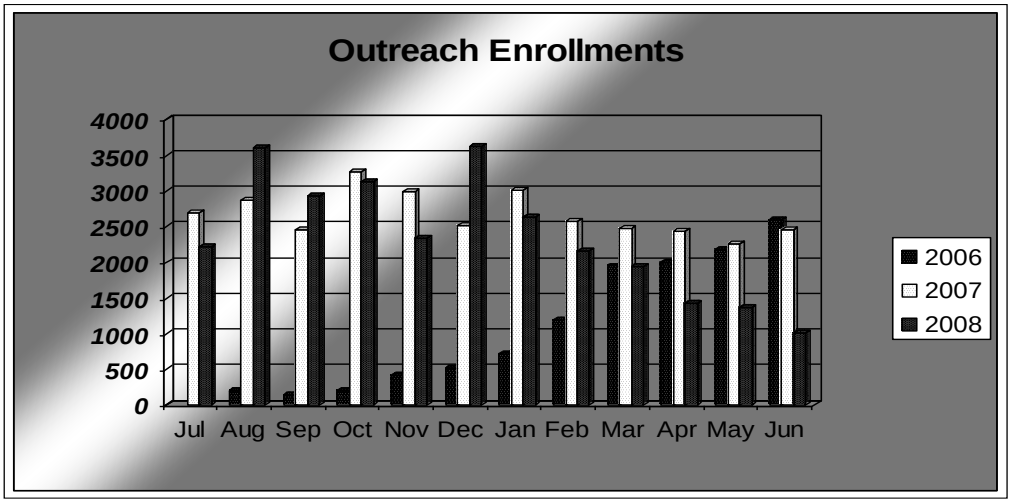
Table 15 Choice Counseling Outreach Activities		
Field Activities	**3rd Quarter**	**4th Quarter**
Group Sessions	603	578
Private Sessions	118	98
Home Visits & One-On-One Sessions	176	107
No Phone List	288	3
Outbound Phone List	7,083	1,113
Enrollments	6,827	3,999
Plan Changes	1,769	4,683

During the 4th quarter the Outreach Team worked Monday-Friday in Medicaid Area Offices during the Staywell and Healthease transition effort. The Team helped 835 beneficiaries who came to meet with a counselor "in-person" and 1,680 who were referred to the Outreach Team by the Agency switchboard.

Public session attendance continued to increase over this quarter with 578 sessions held with 1,210 attendees. There were also 98 private sessions held with a total of 564 attendees. These efforts have resulted in 4,683 plan changes during this quarter, which exceeded the number of enrollments completed. The decrease in enrollments is consistent with the amount of callbacks and plan changes that were made (due to the Staywell and Healthease transition). However, the month of June had a stronger trend toward enrollments versus plan changes as the Staywell and Healthease transition activities started to decline.

Red Alert follow-ups have started to decline this quarter and were close to zero in June. Red Alerts were as high as 3,168 in March. The following chart shows the enrollment activity levels of the Field Choice Counselors since implementation of the demonstration.

Chart B
Field Choice Counseling Outreach Enrollments



Since September of 2007, the Field Choice Counseling activities have been monitored by the quality assurance monitoring staff located in Tallahassee. The quality monitoring staff randomly calls beneficiaries who were served by Field Choice Counselors. The monitors ask four questions to rate the customer service and accuracy of information provided by the Field Choice Counselors. Table 16 shows the responses in percentages from 144 beneficiaries who participated in the surveys (from April-June 2009). The same percentage range used in the Call Center is used in the field, with 100% being a perfect score.

Table 16
Overall Field Choice Counseling Results

Able to complete enrollment/plan change at the session	98.67%
Felt the information provided by the Choice Counselor helped them make an informed decision	97.33%
The information was explained in a way that made it easy to understand	100.00%
The Choice Counselor was friendly/courteous	100.00%

ACS continues to evaluate the monitoring results and has made updates to tools the Field Counselors use for both outbound calls and face-to-face sessions to better serve beneficiaries.

The Field Choice Counselors continued their efforts to better reach the special needs and hard to reach populations. These population groups may be less inclined to enroll over the phone due to physical, mental and other barriers. In addition, some of these populations are transient and may have changed addresses and phone numbers prior to entering the choice process. Efforts to increase outreach to these groups have included providing Choice Counseling opportunities at homeless shelters, mental health provider locations, assisted living facilities and other types of community based organizations that serve these population groups.

The Mental Health Unit:

During the 2nd quarter of Year Three the Outreach/Field team created the Mental Health Unit to provide more direct support to beneficiaries who access mental health services. The Mental Health Unit stayed busy this quarter by continuing to work with community partners to facilitate the transition of Staywell and Healthease members. Those beneficiaries in the special needs community remained a high priority within the unit. The efforts made earlier to build relationships with the organizations and people who serve these individuals are yielding positive results.

During this quarter, 46 private sessions were completed by the Mental Health Unit for 229 attendees, all of whom received services from community partners working with the special needs community. The Mental Health Unit received 244 referrals from community partners for beneficiaries needing counseling but not able to attend

scheduled sessions. The Mental Health Unit conducted 13 staff presentations, continuing the initiative to provide education and information to the case managers and workers serving Medicaid beneficiaries.

To date over 120 organizations have been identified and a contact attempt was made by a Field Choice Counselor. As a result, the Mental Health Unit has established several key relationships and developed strong working partnerships. Some of the large organizations include:

- Susan B. Anthony Recovery Center;
- Bayview Mental Health Facility and Minority Development and Empowerment in Broward County;
- Mental Health Resource Center and River Region Human Services in Duval; and
- Clay County Behavioral Health.

These groups all provide mental health and substance abuse services and have been very receptive to working with the Field Choice Counselors.

5. Health Literacy

The Choice Counseling Special Needs Unit has primary responsibility for the health literacy function. The Special Needs Unit has a Registered Nurse supervisor, and a Licensed Practical Nurse that have both earned their Choice Counseling certification.

Summary of cases taken by the Special Needs Unit:

This quarter there were 30 new case referrals and 41 case reviews received and processed by the Special Needs Unit.

A ‘case referral’ is when a counselor refers a case to the Special Needs Unit through the ACS enrollment system (BESST) for follow up. The Special Needs Unit conducts the research and resolves the referral.

A ‘case review’ is when the Special Needs Unit helps with questions from a Choice Counselor as they are on a call. Most reviews can be handled verbally and quickly. Some case reviews may end up as a referral if there is more research and follow up required by the Special Needs Unit.

This quarter the Special Needs Unit started documenting and reporting on the verbal reviews as noted in the chart below.

	April	May	June
Case Referrals	12	5	13
Case Reviews	14	11	16

The Special Needs Unit staff scope of work has expanded to include:

- Development of additional training for the Choice Counselors working with and serving the medically, mentally or physically complex;
- Enhancements to the scripts to educate beneficiaries on how to access care in a managed care environment;
- Development of health related reference guides to increase the Choice Counselors knowledge of Medicaid services (which is ongoing);
- Participation in the development of the Navigator Choice Counseling script; and
- Development and implementation of a tracking log to capture the number and type of counselor's verbal inquiries which was done during the first portion of the quarter.

6. New Eligible Self Selection Data[2]

The new eligible numbers for self selection have not been reported since July 2008 due to issues with daily file and month end processing transfers from Florida Medicaid's Fiscal Agent (EDS) and ACS Choice Counseling. The Agency, ACS and EDS have identified and created customer service requests (CSRs) to correct the transfer of information, the enrollment, disenrollment and reinstatement processes with the Medicaid system (FMMIS) and the ACS enrollment system (BESST). EDS will work through the program changes and should have the work complete within the next 6 months. The improvements have been made to the daily and monthly files that transfer from EDS to ACS and some issues have been resolved. When the program changes are complete, and the month end information comes through consistently and correctly, it will allow ACS to determine the new eligibles and ensure the enrollment will be more successful. Prior to the Fiscal Agent transition, ACS exceeded the self-selection standard. The Agency fully expects when the corrections are in place, ACS will not only meet but exceed the 80% minimum standard set in the Self Selection Rate for Demonstration Year Three.

The new eligible enrollments in this report are taken from ACS records and are preliminary. There were 86,146 total enrollments for this quarter. Of those enrollments, those that self selected a plan were 19,230 (broken down by month: 5,153 for April; 7,385 for May; and 6,692 for June 2009). There were a total of 66,916 beneficiaries assigned to a plan for the quarter.

7. Complaints/Issues

A beneficiary can file a complaint about the Choice Counseling Program either through the Call Center, Agency headquarters or the Medicaid Area Office. In August of 2007, the Agency and ACS implemented an automated beneficiary survey where complaints

[2] The Agency revised the terminology used to describe voluntary enrollment data to improve clarity and understanding of how the demonstration is working. Instead of referring to new eligible plan selection rate as *"Voluntary Enrollment Rate",* the data is referred to as *"New Eligible Self-Selection Rate"*. The term *"self-selection"* is now used to refer to beneficiaries who choose their own plan and the term *"assigned"* is now used for beneficiaries who do not choose their own plan.

against Choice Counseling can be filed and voice comments can be recorded to describe what occurred on the call.

During the quarter, two complaints were filed related to the Choice Counseling Program. Table 17 provides the details regarding the complaints filed and the action taken by ACS:

Table 17
Choice Counseling Beneficiary Complaints
April 1, 2009 – June 30, 2009

Beneficiary Complaint	Action Taken
1. A beneficiary called to complain that she had tried to disenroll from her health plan when she became pregnant and wanted straight Medicaid during her pregnancy.	➲ Researching the case determined that the disenrollment had been tried, and there were system issues that caused the disenrollment not to process within the Fiscal Agent system. The Agency manually disenrolled the caller from her health plan.
2. A beneficiary called to complain that the disenrollment from her health plan did not take effect. She was pregnant when she made the request.	➲ The counselor apologized and explained that the beneficiary's aid category had changed in the Fiscal Agent system, and she would not be able to make the disenrollment until the beneficiary contacted Florida Department of Children and Families to officially change her information.

8. Quality Improvement

A key component of the Choice Counseling Program is a continuous quality improvement effort. One of the primary elements of the quality improvement process involves the automated survey previously mentioned in this report. The survey results and comments help ACS and the Agency improve customer service to Medicaid beneficiaries. It is imperative for beneficiaries to understand their options and make an informed choice. The survey results reporting the beneficiaries' confidence in the Counselor's ability to explain health plan choices indicate that more than 95% are satisfied with the Choice Counseling experience (both Field and Call Center). ACS continues to focus on improving communication between Counselors and beneficiaries and evaluating comments left by beneficiaries to improve customer service.

Included in this report are comments from beneficiaries who expressed their appreciation to either a Call Center or Field Supervisor for the Choice Counselors who helped them. The individual counselors that received this positive feedback have gone the extra mile and have offered a "helping hand" to those who they spoke with in person or on the phone. These beneficiaries have taken the initiative on their own to contact the supervisors to compliment the work that the counselors have done. During this quarter, there were 38 reported compliments to supervisors about counselors offering

exceptional customer service. Table 18 provides examples of positive feedback about Choice Counselors.

Table 18 **Helping Hands** **Examples of Positive Feedback about Choice Counselors** April 1 through June 31, 2009
A beneficiary called to compliment **Eleyne Best** and said, "I have called many times and for the first time I had excellent customer service. Eleyne was wonderful and kind, she answered all my questions. Thank you for the Choice Counselors Helpline."
A beneficiary who called to compliment **April Hill** said, "I feel like I've finally spoken to someone who knows what they're talking about. I feel so enlightened after talking to April. She did one heck of a job and was able to give me answers to every question I had and relieve all my confusion. I'm so grateful for all her help and sincerely believe she deserves to be commended for the service she provided."
A beneficiary who called to compliment **Sandy Washington** said, "I wanted to compliment the excellent service I received from Sandy. First, I truly appreciate that she took the time to return my call and then with great patience and kindness helped me change the plans. She was so kind and informative. I feel comfortable with everything she helped me do."
A beneficiary who called to compliment **Stephanie Barkley** said, "I just wanted to let you know what a wonderful job Stephanie did, helping with all my questions. She did a fine job and was a pleasure to talk to. She was very helpful and I enjoyed talking with her."
A beneficiary who called to compliment **Demestra Davis** said, "Demestra was outstanding, she exceeded my expectations. When you come across people who make a difference in this world, you have to let someone know. She is professional, compassionate and gave very good information."
I just wanted to personally let you know how much it has helped having the choice counselors in house. They have been so good, professional, helpful and taken a heavy load off of us. I think they are doing an awesome job. Thank you.

ACS distributes individual report cards to each Choice Counselor on their performance. Survey scores and beneficiary comments are also provided to Supervisors and Counselors. The positive comments encourage the Choice Counselor to keep up the good work and the negative comments help to point out possible weaknesses requiring coaching or training.

In addition to external feedback, ACS has implemented an employee feedback email system that allows call center Choice Counselors and Field Choice Counselors to provide immediate comments on issues or barriers that they encounter as part of their daily work. It may be hard at the end of a shift to remember the issues they encountered and this anonymous email box allows the Choice Counselors to send information that is reviewed by management and shared with the Agency.

The Agency Headquarters staff, the Medicaid Area Office staff, and ACS Choice Counseling Program staff continue to utilize the internal feedback loop. This feedback loop involves face-to-face meetings between Area Medicaid staff and ACS Field staff, e-mail boxes on ACS' enrollment system to enable the Agency staff and ACS to share information directly from the system to resolve difficult cases, and regularly scheduled conference calls. ACS has been instrumental in using this feedback loop to inform the Agency at every opportunity about the issues that the call center and field have been facing. They have been creative in their solutions and have moved quickly to implement those solutions.

9. Summary

Overall with a project as large as transitioning to a new Medicaid Fiscal Agent, there are bound to be challenges for everyone as we all learn and work in a new system. The Agency, ACS and EDS remain committed to identifying, prioritizing and resolving these challenges. Recently, additional staffing resources were added to the EDS systems team, with the sole purpose of correcting identified issues and continuing a root cause analysis, as it relates to the demonstration.

ACS continues to work hard to provide excellent customer service to the beneficiaries and has continued to play a key role in identifying and resolving issues as they come up in all areas of their organization. The beneficiary is treated with the highest regard and given the opportunity to make plan selections and changes through whatever process is necessary to help them (including Good Cause plan changes).

Based on historical performance, the Agency believes that the Choice Counseling Program will resume their exceptional performance standards once the daily and month end files are working properly. The Agency has proposed that the Self Selection Rate calculation resume one month after accurate file exchange and the enrollment, disenrollment and reinstatement processes have been established. This will help ensure that the problems have been resolved and a level playing field will be established for ACS to perform. In the mean time, all parties continue to work to meet that goal.

The Agency has been in contact with CMS to discuss the Fiscal Agent transition changes as it relates to Choice Counseling Self-Selection rates. The Agency will continue to communicate with CMS as progress is made.

C. Enrollment Data

Overview

In anticipation of Year One of the demonstration, the Agency developed a transition plan for the purpose of enrolling the existing Medicaid managed care population into the health plans located in the demonstration counties of Broward and Duval. The transition period for Broward and Duval lasted seven months, beginning in September of 2006 and ending in April of 2007. The plan staggered the enrollment of beneficiaries who were enrolled in various managed care programs (operated under Florida's 1915(b) Managed Care Waiver) into demonstration health plans. The types of managed care programs that beneficiaries transitioned from included Health Maintenance Organizations (HMOs), MediPass, Pediatric Emergency Room Diversion, Provider Service Networks (PSNs), and Minority Physician Networks (MPNs).

During the development of the transition plan, consideration was given to the volume of calls the Choice Counseling program would be able to handle each month. The Agency followed the transition schedule outlined below:

- **Non-committed MediPass[3]:** Phased in over 7 months (1/2 in Month 1, then 1/6 in each following month)
- **HMO Population:** 1/12 in Months 2, 3, and 4 and 1/4 in Months 5, 6, 7
- **PSN Population:** 1/3 in each of Months 2, 3, and 4.

During the first quarter of the demonstration, enrollment in health plans was based on this transitional process. Specifically, the July 2006 transition period focused on enrollment of newly eligible beneficiaries as well as half of the MediPass population. Beneficiaries were given 30 days to select a plan. If the beneficiary did not choose a plan, the Choice Counselor assigned them to one. The earliest date of enrollment in a demonstration health plan was September 1, 2006. During the second, third, and fourth quarters of operation (Year One), enrollment in the demonstration increased greatly as more existing Medicaid beneficiaries were transitioned into health plans.

The Agency also developed a transition plan for the Year Two of the demonstration, which expanded the program into the counties of Baker, Clay, and Nassau. Due to the smaller population located in these counties, the transition plan was implemented over a four month period with enrollment beginning in September of 2007 and ending in December 2007. This process was implemented to stagger the enrollment of existing managed care beneficiaries into a demonstration health plan. The beneficiaries were transitioned from HMOs, MediPass, and MPNs. The transition schedule for Baker, Clay and Nassau counties was as follows:

- **September 2007 Enrollment:** Non-committed MediPass located in Baker, Clay, and Nassau Counties.

[3] Non-Committed MediPass beneficiaries are those who had a primary care provider that did not become part of a Medicaid Reform health plan's provider network.

- **October 2007 Enrollment:** Remaining beneficiaries located in Baker and Nassau Counties.
- **November 2007 Enrollment:** Remaining beneficiaries located in Clay County.
- **December 2007 Enrollment:** Clean-up period to transition any remaining beneficiaries located in Baker, Clay, and Nassau Counties.

The demonstration was not expanded in Year Three, and continues to operate in the counties of Baker, Broward, Clay, Duval, and Nassau.

Current Activities

Monthly Enrollment Reports

The Agency provides a comprehensive monthly enrollment report, which includes the enrollment figures for all health plans in the demonstration. This monthly enrollment data is available on the Agency's website at the following URL:

http://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml

Below is a summary of the monthly enrollment in the demonstration for this quarter, beginning April 1, 2009 and ending June 30, 2009. This section contains the following Medicaid Reform enrollment reports:

- Medicaid Reform Enrollment Report
- Medicaid Reform Enrollment by County Report
- Medicaid Reform Voluntary Population Enrollment Report

All health plans located in the five demonstration counties are included in each of the reports. During this quarter, there were a total of 16 health plans – ten HMOs and six fee-for-service PSNs. The HMOs Buena Vista and Vista South Florida, which have been included in previous Year Three reports, both ceased operations during the second quarter of Year Three. As such, they are no longer included in these reports. In addition, the Pediatric Associates PSN ceased operations in February of 2009 (third quarter of Year Three) and had no enrollment in the fourth quarter of Year Three. During this quarter, recipients enrolled in the HMOs Staywell and HealthEase have been transitioning to other health plans due to the withdrawal of these plans from the demonstration areas. This transition will be complete July 1, 2009. There are two categories of Medicaid beneficiaries who are enrolled in the demonstration health plans: Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI). The SSI category is broken down further in the enrollment reports, based on the beneficiaries' eligibility for Medicare. Each enrollment report for this quarter and the process used to calculate the data they contain are described below.

1. Medicaid Reform Enrollment Report

The Medicaid Reform Enrollment Report is a complete look at the entire enrollment for the Medicaid Reform program for the quarter being reported. Table 19 provides a description of each column in the Medicaid Reform Enrollment Report.

Table 19
Medicaid Reform Enrollment Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan; TANF and SSI combined
Market Share for Reform	The percentage of the total Medicaid Reform population that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter

The information provided in this report is an unduplicated count of the beneficiaries enrolled in each Reform health plan at any time during the quarter. Please refer to Table 20 for the Fiscal Year 2008-09, 4th Quarter Medicaid Reform Enrollment Report.

Table 20
Medicaid Reform Enrollment Report
(Fiscal Year 2008-09, 4th Quarter)

Plan Name	Plan Type	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr.
			No Medicare	Medicare Part B	Medicare Parts A & B				
Amerigroup	HMO	21,918	2,586	2	370	**24,876**	**10.06%**	17,663	40.84%
Freedom Health Plan	HMO	995	195	0	29	**1,219**	**0.49%**	1,648	-26.03%
HealthEase	HMO	23,877	3,005	1	337	**27,220**	**11.01%**	50,165	-45.74%
Humana	HMO	14,073	2,637	2	384	**17,096**	**6.91%**	17,912	-4.56%
Molina Healthcare	HMO	4,581	571	1	29	**5,182**	**2.10%**	0	N/A
Preferred Medical Plan	HMO	2,502	576	0	82	**3,160**	**1.28%**	3,892	-18.81%
StayWell	HMO	3,028	241	1	80	**3,350**	**1.35%**	32,049	-89.55%
Total Health Choice	HMO	1,620	2,259	5	317	**20,201**	**8.17%**	7,693	153.69%
United Health Care	HMO	10,939	1,232	1	146	**12,318**	**4.98%**	13,687	-10.00%
Universal Health Care	HMO	6,782	904	0	183	**7,869**	**3.18%**	6,393	23.09%
HMO Total	**HMO**	**106,315**	**14,206**	**13**	**1,957**	**122,491**	**49.54%**	**151,372**	**-19.08%**
Access Health Solutions	PSN	49,113	5,716	1	808	**55,638**	**22.50%**	37,547	48.18%
Better Health, LLC	PSN	4,020	476	0	22	**4,518**	**1.83%**	0	N/A
CMS	PSN	2,962	2,737	0	52	**5,751**	**2.33%**	5,080	13.21%
First Coast Advantage	PSN	25,532	4,640	0	730	**30,902**	**12.50%**	23,377	32.19%
NetPass	PSN	6,658	1,832	1	335	**8,826**	**3.57%**	7,467	18.20%
Pediatric Associates	PSN	0	0	0	0	**0**	**0.00%**	515	-100.00%
SFCCN	PSN	15,711	2,964	0	463	**19,138**	**7.74%**	11,017	73.71%
PSN Total		**103,996**	**18,365**	**2**	**2,410**	**124.773**	**50.46%**	**85,003**	**46.79%**
Reform Enrollment Totals		**210,311**	**32,571**	**15**	**4,367**	**247,264**	**100.00%**	**236,375**	**4.61%**

The demonstration market share percentage for each plan is calculated once all beneficiaries have been counted and the total number of beneficiaries enrolled is known.

The enrollment figures for this quarter reflect those beneficiaries who self-selected a health plan as well as those who were mandatorily assigned to one. In addition, some Medicaid beneficiaries transferred from Non-Reform health plans to Reform health plans. There were a total of 247,264 beneficiaries enrolled in the demonstration during this quarter. There were 16 demonstration health plans with market shares ranging from 0.49 percent to 22.50 percent.

2. Medicaid Reform Enrollment by County Report

During this quarter the demonstration remained operational in five counties: Baker, Broward, Clay, Duval, and Nassau. The number of HMOs and PSNs in each of the demonstration counties county is listed in Table 21 on the following page.

Table 21 Number of Reform Health Plans in Demonstration Counties		
County Name	**# of Reform HMOs**	**# of Reform PSNs**
Baker	**1**	**1**
Broward	**9**	**5**
Clay	**1**	**1**
Duval	**4**	**3**
Nassau	**1**	**1**

The Medicaid Reform Enrollment by County Report is similar to the Medicaid Reform Enrollment Report; however, it has been broken down by county. The demonstration counties are listed alphabetically, beginning with Baker County and ending with Nassau County. For each county, HMOs are listed first, followed by PSNs. Table 22 provides a description of each column in the Medicaid Reform Enrollment by County Report.

Table 22 Medicaid Reform Enrollment by County Report Descriptions	
Column Name	**Column Description**
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
# TANF Enrolled	The number of TANF beneficiaries enrolled with the plan in the county listed
# SSI Enrolled - No Medicare	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have no additional Medicare coverage
# SSI Enrolled - Medicare Part B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have additional Medicare Part B coverage
# SSI Enrolled - Medicare Parts A & B	The number of SSI beneficiaries who are enrolled with the plan in the county listed and who have addition Medicare Parts A and B coverage
Total # Enrolled	The total number of beneficiaries enrolled with the plan in the county listed; TANF and SSI combined
Market Share For Reform by County	The percentage of the Medicaid Reform population in the county listed that the plan's beneficiary pool accounts for
Enrolled in Prev. Qtr.	The total number of beneficiaries (TANF and SSI) who were enrolled in the plan in the county listed during the previous reporting quarter
% Increase From Prev. Qtr.	The change in percentage of the plan's enrollment from the previous reporting quarter to the current reporting quarter (in the county listed)

In addition, the total Medicaid Reform enrollment counts are included at the bottom of the report, shown as in Table 23 and located on the following page.

Table 23
Medicaid Reform Enrollment by County Report
(Fiscal Year 2008-09, 4th Quarter)

Plan Name	Plan Type	Plan County	# TANF Enrolled	# SSI Enrolled			Total # Enrolled	Market Share For Reform by County	Enrolled in Prev. Qtr.	% Increase From Prev. Qtr
				No Medicare	Medicare Part B	Medicare Parts A & B				
United Health Care	HMO	Baker	627	86	0	14	**727**	**23.27%**	775	-6.19%
Access Health Solutions	PSN	Baker	2,152	213	0	32	**2,397**	**76.73%**	2,178	10.06%
Total Reform Enrollment for Baker			**2,779**	**299**	**0**	**46**	**3,124**	**100.00%**	**2,953**	**5.79%**
Amerigroup	HMO	Broward	21,918	2,586	2	370	**24,876**	**18.33%**	17,663	40.84%
Freedom Health Plan	HMO	Broward	995	195	0	29	**1,219**	**0.90%**	1,648	-26.03%
HealthEase	HMO	Broward	683	77	1	21	**786**	**0.58%**	13,494	-94.20%
Humana	HMO	Broward	14,073	2,637	2	384	**17,096**	**12.60%**	17,912	-4.56%
Molina Healthcare	HMO	Broward	4,581	571	1	29	**5,182**	**3.82%**	0	N/A
Preferred Medical Plan	HMO	Broward	2,502	576	0	82	**3,160**	**2.33%**	3,892	-18.81%
StayWell	HMO	Broward	2,860	218	1	75	**3,154**	**2.32%**	29,474	-89.30%
Total Health Choice	HMO	Broward	17,620	2,259	5	317	**20,201**	**14.88%**	7,963	153.69%
Universal Health Care	HMO	Broward	3,349	525	0	100	**3,974**	**2.93%**	2,682	48.17%
Access Health Solutions	PSN	Broward	17,766	2,067	1	284	**20,118**	**14.82%**	13,052	54.14%
Better Health, LLC	PSN	Broward	4,020	476	0	22	**4,518**	**3.33%**	0	N/A
CMS	PSN	Broward	1,701	1,737	0	33	**3,471**	**2.56%**	3,014	15.16%
Netpass	PSN	Broward	6,658	1,832	1	335	**8,826**	**6.50%**	7,467	18.20%
Pediatric Associates	PSN	Broward	0	0	0	0	**0**	**0.00%**	515	-100.00%
SFCCN	PSN	Broward	15,711	2,964	0	463	**19,138**	**14.10%**	11,017	73.71%
Total Reform Enrollment for Broward			**114,437**	**18,720**	**14**	**2,544**	**135,715**	**100.00%**	**129,793**	**4.56%**
United Health Care	HMO	Clay	3,414	260	0	32	**3,706**	**32.70%**	3,718	-0.32%
Access Health Solutions	PSN	Clay	6,750	760	0	116	**7,626**	**67.30%**	6,759	12.83%
Total Reform Enrollment for Clay			**10,164**	**1,020**	**0**	**148**	**11,332**	**100.00%**	**10,477**	**8.16%**
HealthEase	HMO	Duval	23,194	2,928	0	316	**26,438**	**28.68%**	36,671	-27.90%
StayWell	HMO	Duval	168	23	0	5	**196**	**0.21%**	2,575	-92.39%
United Health Care	HMO	Duval	5,856	749	1	91	**6,697**	**7.26%**	7,889	-15.11%
Universal Health Care	HMO	Duval	3,433	379	0	83	**3,895**	**4.22%**	3,711	4.96%
Access Health Solutions	PSN	Duval	19,148	2,322	0	320	**21,790**	**23.63%**	12,231	78.15%
CMS	PSN	Duval	1,261	1,000	0	19	**2,280**	**2.47%**	2,066	10.36%
First Coast Advantage	PSN	Duval	25,532	4,640	0	730	**30,902**	**33.52%**	23,377	32.19%
Total Reform Enrollment for Duval			**78,592**	**12,041**	**1**	**1,564**	**92,198**	**100.00%**	**88,520**	**4.15%**
United Health Care	HMO	Nassau	1,042	137	0	9	**1,188**	**24.27%**	1,305	-8.97%
Access Health Solutions	PSN	Nassau	3,297	354	0	56	**3,707**	**75.73%**	3,327	11.42%
Total Reform Enrollment for Nassau			**4,339**	**491**	**0**	**65**	**4,895**	**100.00%**	**4,632**	**5.68%**
Reform Enrollment Totals			**210,311**	**32,571**	**15**	**4,367**	**247,264**		**236,375**	**4.61%**

As with the Medicaid Reform Enrollment Report, the beneficiaries are extracted from the monthly Medicaid eligibility file and are then counted uniquely based on what plan the beneficiary is enrolled in. The unique beneficiary counts are separated by the counties in which the plans operate.

During this quarter, there was an enrollment of 3,124 beneficiaries in Baker County, 135,715 beneficiaries in Broward County, 11,332 beneficiaries in Clay County, 92,198 beneficiaries in Duval County, and 4,895 beneficiaries in Nassau County. There were two Baker County health plans with market shares ranging from 23.27 percent to 76.73 percent, 14 Broward County health plans with market shares ranging from 0.58 percent to 18.33 percent, two Clay County health plans with market shares ranging from 32.70 percent to 67.30 percent, seven Duval County health plans with market shares ranging from 0.21 percent to 33.52 percent, and two Nassau County health plans with market shares ranging from 24.27 percent to 75.73 percent.

3. Medicaid Reform Voluntary Population Enrollment Report

The populations identified in Tables 24 and 25 may voluntarily enroll in a Medicaid Reform health plan. The voluntary populations include individuals classified as Foster Care, SOBRA, Refugee, Developmental Disabilities, or Dual-Eligible (enrolled in both Medicaid and Medicare). The Medicaid Reform Voluntary Population Enrollment Report provides a count of both the new and existing beneficiaries in each of these categories who chose to enroll in a Medicaid Reform health plan. Table 24 provides a description of each column in this report.

Table 24
Medicaid Reform Voluntary Population Enrollment Report Descriptions

Column Name	Column Description
Plan Name	The name of the Medicaid Reform plan
Plan Type	The plan's type (HMO or PSN)
Plan County	The name of the county the plan operates in (Baker, Broward, Clay, Duval, or Nassau)
Foster, Sobra, and Refugee	The number of unique Foster Care, SOBRA, or Refugee beneficiaries who voluntarily enrolled in a plan during the current reporting quarter
Developmental Disabilities	The number of unique beneficiaries diagnosed with a developmental disability who voluntarily enrolled in a plan during the current reporting quarter
Dual-Eligibles	The number of unique dual-eligible beneficiaries who voluntarily enrolled in a plan during the current reporting quarter
Total	The total number of voluntary population beneficiaries who enrolled in Medicaid Reform during the current reporting quarter
Medicaid Reform Total Enrollment	The total number of Medicaid Reform beneficiaries enrolled in the health plan during the reporting quarter

Table 25 lists the number of individuals in the voluntary populations who chose to enroll in the demonstration, as well as the percentage of the Medicaid Reform population that they represent.

Table 25
Medicaid Reform Voluntary Population Enrollment Report
(Fiscal Year 2008-09, 4th Quarter)

Plan Name	Plan Type	Plan County	Reform Voluntary Populations								Medicaid Reform Total Enrollment
			Foster, SOBRA, and Refugee		Developmental Disabilities		Dual-Eligibles		Total		
			New	Existing	New	Existing	New	Existing	Number	Percentage	
Amerigroup	HMO	Broward	4	115	0	3	41	55	**218**	**0.88%**	**24,876**
Freedom Health Plan	HMO	Broward	0	5	0	0	0	3	**8**	**0.66%**	**1,219**
HealthEase	HMO	Broward	0	97	0	4	0	31	**132**	**16.88%**	**782**
HealthEase	HMO	Duval	0	521	0	14	0	74	**609**	**2.30%**	**26,438**
Humana	HMO	Broward	1	87	0	6	27	130	**251**	**1.47%**	**17,096**
Molina Healthcare	HMO	Broward	4	0	0	0	21	1	**26**	**0.50%**	**5,182**
Preferred Medical Plan	HMO	Broward	0	34	0	1	0	27	**62**	**1.96%**	**3,160**
Staywell	HMO	Broward	0	133	0	12	0	58	**203**	**6.44%**	**3,154**
Staywell	HMO	Duval	0	38	0	0	0	10	**48**	**24.49%**	**196**
Total Health Choice	HMO	Broward	17	45	0	2	91	87	**242**	**1.20%**	**20,201**
United Healthcare	HMO	Baker	0	7	0	0	0	2	**9**	**1.24%**	**727**
United Healthcare	HMO	Clay	1	37	0	2	2	6	**48**	**1.30%**	**3,706**
United Healthcare	HMO	Duval	0	161	0	5	0	18	**184**	**2.75%**	**6,697**
United Healthcare	HMO	Nassau	0	12	0	0	1	1	**14**	**1.18%**	**1,188**
Universal	HMO	Broward	2	9	0	0	22	26	**59**	**1.48%**	**3,974**
Universal	HMO	Duval	4	35	0	0	16	25	**80**	**2.05%**	**3,895**
HMO Total	**HMO**		**33**	**1,336**	**0**	**49**	**221**	**554**	**2,193**	**1.79%**	**122,491**
Access Health Solutions	PSN	Baker	0	23	0	0	1	12	**36**	**1.50%**	**2,397**
Access Health Solutions	PSN	Broward	2	126	1	3	27	100	**259**	**1.29%**	**20,118**
Access Health Solutions	PSN	Clay	5	59	0	3	7	62	**136**	**1.78%**	**7,626**
Access Health Solutions	PSN	Duval	16	182	1	6	49	152	**406**	**1.86%**	**21,790**
Access Health Solutions	PSN	Nassau	1	57	0	0	4	27	**89**	**2.40%**	**3,707**
Better Health, LLC	PSN	Broward	2	1	0	0	16	0	**19**	**0.42%**	**4,518**
CMS	PSN	Broward	0	43	0	20	0	11	**74**	**2.13%**	**3,471**
CMS	PSN	Duval	0	55	0	14	0	1	**70**	**3.07%**	**2,280**
NetPass	PSN	Broward	1	50	0	2	18	227	**298**	**3.38%**	**8,826**
SFCCN	PSN	Broward	12	281	0	5	44	281	**623**	**3.26%**	**19,138**
First Coast Advantage	PSN	Duval	26	371	0	22	79	493	**991**	**3.21%**	**30,902**
PSN Total	**PSN**		**65**	**1,248**	**2**	**75**	**245**	**1,366**	**3,001**	**2.41%**	**124,773**
Reform Enrollment Totals			**98**	**2,584**	**2**	**124**	**466**	**1,920**	**5,194**	**2.10%**	**247,264**

Demonstration Year One and Year Two quarterly reports have included an additional report that displays a summary of Self-Selection, Assignment Rates, and Disenrollment data. In July of 2008, the Agency transitioned to a new Fiscal Agent and subsequently, the entire Medicaid data system was overhauled. At this time, the data necessary to calculate the values of this report are not available. However, future quarterly reports will include this report as soon as the data is available.

D. Opt Out Program

Overview

In January 2006, the Agency began developing a process to ensure all beneficiaries who have access to employer sponsored insurance (ESI) are provided the opportunity to opt out of Medicaid and select an ESI plan. The Agency decided to contract with Health Management Systems, Inc. (HMS), to administer the Opt Out program. HMS submitted its proposal on March 31, 2006 which included a description of the Opt Out process for contacting beneficiaries, contacting employers, establishing the premium payment process and maintaining the Opt Out Program database. The Agency entered into a contract with HMS to conduct the Opt Out Program on July 1, 2006.

In April 2006, the Agency began planning outreach activities for employers located in Broward and Duval Counties. The Agency mailed letters to major employers in the pilot counties beginning in June 2006, notifying them of the Medicaid Reform Opt Out Program and providing them a summary of the Opt Out process. The Agency conducted nine conference calls with several large employers to answer questions and request they accept premiums on behalf of Opt Out enrollees.

An Invitation to Negotiate was released during the third quarter of Year Two on January 22, 2008 for Third Party Liability Recovery Services that included the Opt Out Program. ACS State Healthcare, LLC (ACS) was awarded the contract and took over administration of the Opt Out Program effective November 1, 2008. The contract with the former vendor, HMS, expired on October 31, 2008. In conjunction with ACS, the Agency ensured that the vendor transition was smooth and seamless for all program participants.

<u>Description of Opt Out Process</u>

Medicaid beneficiaries interested in the Opt Out Program are either referred to the current vendor by the Choice Counseling Program or they contact the vendor directly. The beneficiary is provided the toll-free number for the Opt Out Program so he or she may follow-up directly with the vendor if preferred. A new Referral form requesting employer information is completed over the phone with an Opt Out specialist or is sent to the beneficiary for completion. A release form is also sent to the beneficiary, giving the vendor permission to contact their employer.

After the signed release is received from the beneficiary, an Opt Out specialist sends the employer an Employer Questionnaire requesting the following information: Is health insurance available? Is the individual eligible for health insurance? What is the plan type? Who is the insurance company? What is the premium amount and frequency? When is the open enrollment period?

After the required information from the employer is received, the Opt Out specialist follows up with the beneficiary to discuss the insurance that is available through their employer, how much the premium will be and how payment of the premium will be

processed. The beneficiary then decides whether he or she wants to opt out of Medicaid. The beneficiary is also encouraged throughout this process to contact the employer directly to receive detailed information on the benefits available through the employer. After enrollment into the Opt Out Program, the beneficiary is sent an Enrollment Letter that confirms the beneficiary is enrolled in the Opt Out Program. The vendor then begins to process the premiums according to the required frequency. If the beneficiary is unable to enroll in the Opt Out Program (e.g., not open enrollment), the beneficiary is sent an Opt Out denial letter. The Opt Out database is flagged to contact the beneficiary when he or she is eligible for the Opt Out Program.

The Opt Out database has been designed to comply with the Special Terms and Conditions of the 1115 Medicaid Reform Waiver. The database tracks enrollee characteristics such as eligibility category, type of employer-sponsored insurance and type of coverage. The database will also track the reason for an individual disenrolling in an ESI program and track enrollees who elect the option to reenroll in a Medicaid Reform plan. To date no enrollee has chosen to disenroll from Opt Out into a Medicaid Reform plan. The Agency has developed a plan to monitor the Opt Out Program vendor's performance under the contract.

Current Activities

During this quarter, the vendor has continued to monitor program participants, ensuring that they continually meet the established eligibility requirements.

The Agency monitored the Opt Out process on a regular basis to ensure that it continues to be an effective and efficient process for all interested beneficiaries. No major problems were identified during this quarter that required the Agency to make any changes to the process.

Opt Out Program Statistics

- 61 individuals have enrolled in the Opt Out Program since September 1, 2006.
- 40 individuals have disenrolled from the Opt Out Program due to loss of job, loss of Medicaid eligibility or disenrollment from commercial insurance since September 1, 2006.
- At the end of the fourth quarter of Year Three, there are currently 21 individuals enrolled in the Opt Out Program.

A description of the Opt Out enrollees is provided below.

1. The caller was enrolled in the Opt Out Program during the second quarter of Year One with a coverage effective date of October 1, 2006. The individual lost her job during the third quarter of Year One and was subsequently disenrolled from the Opt Out Program on February 28, 2007. The individual worked for a large employer and had elected to use the Medicaid Opt Out medical premium to pay the employee portion for single coverage.

2. The caller began the process to enroll his five Medicaid eligible children in the Opt Out Program during the second quarter of Year One. The effective date for enrollment in the Opt Out Program was January 1, 2007, at the start of the third quarter of Year One. The father has health insurance available through his employer. The father elected to use his five children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The five children's Medicaid eligibility ended February 28, 2007, and they were subsequently disenrolled from the Opt Out Program.

3. The caller began the process to enroll his four children in the Opt Out Program during the second quarter of Year One. The effective date for enrollment was during the third quarter of Year One on February 1, 2007. The father of the children has health insurance available through his employer. The father elected to use his four children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The four children's Medicaid eligibility ended December 31, 2007 and they were subsequently disenrolled from the Opt Out Program.

4. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Year One. The effective date for enrollment was during the fourth quarter of Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan effective December 31, 2007. Therefore, the two children were disenrolled from the Opt Out Program. The mother has subsequently found new employment and re-enrolled her children in the Opt Out Program during the third quarter of Year Two on January 1, 2008. The children's Medicaid eligibility ended March 31, 2008 and they were subsequently disenrolled from the Opt Out Program (Item Number 11).

5. The caller began the process to enroll her two children in the Opt Out Program during the fourth quarter of Year One. The effective date for enrollment was during the fourth quarter of Year One on June 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended March 31, 2008. As a result, this child has been disenrolled from the Opt Out Program. The other child remains Medicaid eligible and is still enrolled in the Opt Out Program.

6. The caller began the process to enroll her child in the Opt Out Program during the first quarter of Year Two. The effective date for enrollment was during the first quarter of Year Two on August 1, 2007. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended April 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.

7. The caller began the process to enroll his child in the Opt Out Program during the first quarter of Year Two. The effective date for enrollment was during the first quarter of Year Two on September 1, 2007. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended June 30, 2008. As a result, the child has been disenrolled from the Opt Out program.

8. The caller began the process to enroll her three children during the first quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her three children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. All three children are still enrolled in the Opt Out Program.

9. The caller began the process to enroll her two children during the first quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on October 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. Both children are still enrolled in the Opt Out Program.

10. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the second quarter of Year Two on November 1, 2007. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan during the third quarter of year two effective March 31, 2008. As a result, the children have been disenrolled from the Opt Out program.

11. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. Both children's Medicaid eligibility ended March 31, 2008. As a result, the children have been disenrolled from the Opt Out Program.

12. The caller began the process to enroll her two children during the second quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on January 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. One of the children's Medicaid eligibility ended February 29, 2008. As a result, this child was disenrolled from the Opt Out Program. The other child's Medicaid eligibility ended March 31, 2009 and as a result has been disenrolled from the Opt Out Program. The first disenrolled child became Medicaid eligible again during the fourth quarter of Year Two and subsequently re-enrolled in the

Opt Out Program effective May 1, 2008. The child's Medicaid eligibility ended March 31, 2009, and as a result, has been disenrolled from the Opt Out Program (Item Number 26).

13. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on February 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended November 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

14. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on February 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

15. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The mother disenrolled from her employer's health insurance plan during the third quarter of Year Three effective February 28, 2009. As a result, the child has been disenrolled from the Opt Out program.

16. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The father lost his job during the first quarter of Year Three effective September 26, 2008. As a result, the child has been disenrolled from the Opt Out Program.

17. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the third quarter of Year Two on March 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended November 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

18. The caller began the process to enroll his two children during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his two children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The father lost his job during the first quarter of Year Three effective

August 12, 2008. As a result, the children have been disenrolled from the Opt Out Program.

19. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for single coverage. The individual's Medicaid eligibility ended September 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

20. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended May 31, 2008. The child has subsequently been disenrolled from the Opt Out Program.

21. The caller began the process to enroll his child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The father of the child has health insurance available through his employer. The father elected to use his child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

22. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended November 30, 2008. As a result, the child has been disenrolled from the Opt Out Program.

23. The caller began the process to enroll during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual's Medicaid eligibility ended April 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

24. The caller began the process to enroll her child in the Opt Out Program during the third quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on April 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended January 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.

25. The caller began the process to enroll during the fourth quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on May 1, 2008. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for family coverage. The individual lost his job during the fourth quarter of Year Two effective June 30, 2008. As a result, the individual has been disenrolled from the Opt Out Program.

26. The caller began the process to enroll her child in the Opt Out Program during the fourth quarter of Year Two. The effective date for enrollment was during the fourth quarter of Year Two on May 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child's Medicaid eligibility ended March 31, 2009. As a result, the child has been disenrolled from the Opt Out Program.

27. The caller began the process to enroll his four children in the Opt Out Program during the fourth quarter of Year Two. The effective date for enrollment was during the first quarter of Year Three on July 1, 2008. The father of the children has health insurance available through his employer. The father elected to use his children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The children's Medicaid eligibility ended February 28, 2009. As a result, all four children have been disenrolled from the Opt Out Program.

28. The caller began the process to enroll his child in the Opt Out Program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on November 1, 2008. The mother of the child has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

29. The caller began the process to enroll in the Opt Out Program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on October 1, 2008. The individual has health insurance available through her employer. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for individual coverage. The child is still enrolled in the Opt Out Program.

30. The caller began the process to enroll her five children in the Opt Out Program during the second quarter of Year Three. The effective date for enrollment was during the second quarter of Year Three on December 1, 2008. The mother of the children has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. All five children are still enrolled in the Opt Out Program.

31. The caller began the process to enroll her child in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during

the second quarter of Year Three on December 1, 2008. The father has health insurance available through a COBRA coverage continuation plan. The father of the child is self-employed and has elected to use his child's Medicaid Opt Out premium to pay for their family coverage. The child is still enrolled in the Opt Out Program.

32. The caller began the process to enroll her two children in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. Both children are still enrolled in the Opt Out Program.
33. The caller began the process to enroll herself and her two children in the Opt Out program during the second quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on January 1, 2009. The mother has health insurance available through her employer. The mother elected to use her and her children's Medicaid Opt Out medical premiums to pay the employee portion for their family coverage. The Medicaid eligibility for the mother and one of the children ended during the fourth quarter of Year Three on June 30, 2009. As a result, they have both been disenrolled from the Opt Out program. The other child remained Medicaid eligible and is still enrolled in the Opt Out program.
34. The caller began the process to enroll in the Opt Out program during the third quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on March 1, 2009. The individual has health insurance available through her employer. The individual works for a large employer and has elected to use the Medicaid Opt Out medical premium to pay the employee portion for her family coverage. The individual is still enrolled in the Opt Out Program.
35. The caller began the process to enroll her child in the Opt Out program during the third quarter of Year Three. The effective date for enrollment was during the third quarter of Year Three on March 1, 2009. The mother has health insurance available through her employer. The mother elected to use her child's Medicaid Opt Out medical premium to pay the employee portion for their family coverage. The child is still enrolled in the Opt Out Program.

Table 26 provides the Opt Out Program Statistics for each enrollment in the program beginning on September 1, 2006, and ending June 30, 2009. Current Opt Out enrollment, as of June 30, 2009, is 21.

Table 26
Opt Out Statistics
September 1, 2006 – June 30, 2009

Eligibility Category	Effective Date of Enrollment	Type of Employer Sponsored Plan	Type of Coverage	Number of Beneficiaries Enrolled	Effective Date of Disenrollment	Reason for Disenrollment
C & F	10/01/06	Large Employer	Single	1	02/28/07	Loss of Job
C & F	01/01/07	Large Employer	Family	5	02/28/07	Loss of Medicaid Eligibility
C & F	02/01/07	Large Employer	Family	4	12/31/07	Loss of Medicaid Eligibility
C & F	06/01/07	Large Employer	Family	2	12/31/07	Disenrolled from Commercial Insurance
C & F	06/01/07	Large Employer	Family	1 1	03/31/08 N/A	Loss of Medicaid Eligibility N/A
C & F	08/01/07	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	09/01/07	Small Employer	Family	1	06/30/08	Loss of Medicaid Eligibility
C & F	10/01/07	Large Employer	Family	3	N/A	N/A
C & F	10/01/07	Large Employer	Family	2	N/A	N/A
C & F	11/01/07	Large Employer	Family	2	03/31/08	Disenrolled from Commercial Insurance
C & F	01/01/08	Large Employer	Family	2	03/31/08	Loss of Medicaid Eligibility
C & F	01/01/08	Large Employer	Family	1 1	02/29/08 03/31/09	Loss of Medicaid Eligibility Loss of Medicaid Eligibility
C & F	02/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
SSI	02/01/08	Large Employer	Family	1	N/A	N/A
C & F	03/01/08	Large Employer	Family	1	02/28/09	Disenrolled from Commercial Insurance
C & F	03/01/08	Large Employer	Family	1	09/26/08	Loss of Job
C & F	03/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	2	08/12/08	Loss of Job
C & F	04/01/08	Large Employer	Single	1	09/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	05/31/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	N/A	N/A
C & F	04/01/08	Large Employer	Family	1	11/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	04/30/08	Loss of Medicaid Eligibility
C & F	04/01/08	Large Employer	Family	1	01/31/09	Loss of Medicaid Eligibility
C & F	05/01/08	Large Employer	Family	1	06/30/08	Loss of Job
C & F	05/01/08	Large Employer	Family	1	03/31/09	Loss of Medicaid Eligibility
C & F	07/01/08	Large Employer	Family	4	02/28/09	Loss of Medicaid Eligibility
C & F	11/01/08	Large Employer	Family	1	N/A	N/A
C & F	10/01/08	Large Employer	Single	1	N/A	N/A
C & F	12/01/08	Large Employer	Family	5	N/A	N/A
C & F	12/01/08	COBRA	Family	1	N/A	N/A
C & F	01/01/09	Large Employer	Family	2	N/A	N/A
SSI C & F	01/01/09	Large Employer	Family	2 1	06/30/09 N/A	Loss of Medicaid Eligibility N/A
C & F	03/01/09	Large Employer	Family	1	N/A	N/A
SSI	03/01/09	Large Employer	Family	1	N/A	N/A

*C & F - Children & Family
*SSI - Supplemental Security Income

E. Enhanced Benefits Account Program

Overview

The Enhanced Benefits Account Program (EBAP) component of Reform is designed as an incentive program to promote and reward participation in healthy behaviors. All Medicaid beneficiaries who enroll in a Medicaid Reform Health Plan are eligible for the program. No separate application or process is required to enroll in EBAP.

Beneficiaries enrolled in a Medicaid Reform health plan may earn up to $125.00 worth of credits per state fiscal year. Credits are posted to individual accounts that are established and maintained within the Florida Fiscal Agent's (EDS) pharmacy point of sale system currently maintained and managed by the EDS subcontractor First Health. Any earned credits may be used to purchase approved health related products and supplies at any Medicaid participating pharmacy. Purchases must be made at the pharmacy prescription counter using the beneficiary's Medicaid Gold Card or Medicaid identification number and a picture ID.

The Agency approves credits for participation of approved healthy behaviors using date of service, eligibility, and approved behavior edits within a database referred to as the Enhanced Benefits Information System (EBIS). All Medicaid Reform health plans are required to submit monthly reports for their Reform members who had paid claims for approved healthy behaviors within the prior month. These reports are uploaded into the EBIS database for processing and approval. Once a healthy behavior is approved and the appropriate credit is applied, the information is sent to the EDS subcontractor First Health to be loaded in the Pharmacy Point of Sale System.

Current Activities

1. Call Center Activities

During this quarter, the Enhanced Benefits Call Center, located in Tallahassee, Florida, continued to operate a toll-free number as well as a toll-free number for the hearing impaired callers. The call center is staffed with employees who speak English, Spanish, and Haitian Creole. In addition, a language line is used to assist with calls in over 100 languages. The operation hours are 8:00 a.m. - 8:00 p.m., Monday – Thursday, and 8:00 a.m. - 7:00 p.m. on Friday.

The primary function of the call center is to handle inbound calls from beneficiaries and answer questions on the program and provide information on credits earned and used by beneficiaries. The majority of the calls for this quarter were related to beneficiaries requesting information regarding their account balances. A total of 13,549 calls or 77% of all answered calls were related to account balances.

The following is a highlight of the call volume during the quarter:

Inbound Calls:	**18,422**
Calls Abandoned:	**822**
Average Talk Time:	**4.5 minutes**

2. System Activities

The Agency continues to receive the monthly healthy behavior reports from the plans as scheduled by the 10th day each month. The Enhanced Benefits Information System (EBIS) continues to operate effectively and efficiently in processing the enhanced benefit credits. The healthy behavior reports are uploaded each month as designed for processing and credit approval. The system continues to generate a monthly credit report to each recipient who has activity for the month and a quarterly statement process for recipients who have a balance only with no new activity.

3. Outreach and Education for Beneficiaries

The mailing of the welcome letter and the beneficiary coupon statements continued during the quarter. The calls received this quarter were primarily related to beneficiaries seeking current balance information. The counselors are able to provide up to date information to each beneficiary, covering the latest weekly balances.

The Agency is currently reviewing a Statement of Understanding (SOU) from the Agency's pharmacy point of sale vendor, First Health. The SOU offers an Interactive Voice Response (IVR) solution to handle the balance only calls. It has been submitted to the Fiscal Agent for review. The Agency is also waiting to receive a proposal from ACS, the choice counseling vendor, to handle balance related calls through an Interactive Voice Response solution as well.

4. Outreach and Education for Pharmacies

No activities related to outreach and education for the pharmacies was provided this quarter.

5. Enhanced Benefits Advisory Panel

The Enhanced Benefits Advisory Panel is scheduled to meet August 11, 2009. During this meeting, the focus will be discussion about adding additional healthy behaviors that are preventive such as blood tests and screenings.

6. Enhanced Benefits Statistics

Table 27 provides the Enhanced Benefit Account Program statistics beginning April 1, 2009 and ending June 30, 2009.

Table 27 Enhanced Benefit Account Program Statistics				
4th Quarter Activities – Year Three		**April 2009**	**May 2009**	**June 2009**
I.	Number of plans submitting reports by month in each county	28 of 28	28 of 28	29 of 29
II.	Number of enrollees who received credit for healthy behaviors by month	27,369	25,261	23,239
III.	Total dollar amount credited to accounts by each month	$579,320.00	$516,962.50	$488,720.00
IV.	Total cumulative dollar amount credited through the end each month	$20,798,531.16	$21,315,493.66	$21,804,213.66
V.	Total dollar amount of credits used each month by date of service	$496,206.27	$517,902.54	$491,410.45
VI.	Total cumulative dollar amount of credits used through the month by date of service	$7,921,095.66	$8,438,998.20	$8,930,408.65
VII.	Total cumulative number of enrollees who used credits each month	110,489	116,016	120,935

7. Complaints

A beneficiary can file a complaint about the EBAP through the call center and those complaints are documented in the system utilized by the call center and reported to the Agency on a weekly basis. The complaints are reviewed and worked by the Agency to resolve the issue the beneficiary is having regarding the program. The primary reason for complaints this quarter are issues surrounding the health plans not submitting healthy behaviors to the Agency.

During this quarter, over 17,000 beneficiaries purchased one or more products with their Enhanced Benefits credits, and 47 (less than 1%) complaints were recorded through the call center related to the EBAP. Table 28 provides a summary of the complaints received this quarter and outlines the actions taken by either the Agency or EDS (through First Health) to address the issues raised.

Table 28 Enhanced Benefit Beneficiary Complaints	
Beneficiary Complaint	**Action Taken**
1. Nineteen beneficiaries called to complain that the pharmacy didn't allow them to purchase items, or they had difficulty in purchasing items, or the pharmacy was unaware of the program, or the pharmacy staff was rude to the beneficiary.	➲ The Agency continues to provide technical/educational assistance to pharmacies regarding the Enhanced Benefits Account Program. Call center also refers beneficiaries to an actively participating pharmacy in their area.
2. Twenty one beneficiaries complained about healthy behaviors not submitted by the health plan on behalf of the beneficiary.	➲ The Agency researches with each health plan regarding healthy behaviors not submitted. In most cases the health plan submitted the behaviors in the next report submission. In a few cases, some beneficiaries had already reached occurrence limits on some of the behaviors, therefore credit would not have been credited to the beneficiary account.
3. Seven beneficiaries complained about the balance in their account, either regarding pricing of products or duplicate pricing of one item.	➲ The Agency researched along with the pharmacy vendor regarding these complaints. The vendor was able to resolve issue with the pharmacy.

F. Low Income Pool

Overview

In accordance with the Special Terms and Conditions #100 of the Florida Medicaid 1115 Demonstration Waiver, the Agency has met all the specified pre-implementation milestones. The availability of funds for the Low Income Pool (LIP) in the amount of $1 billion is contingent upon these pre-implementation milestones being met.

On February 3, 2006, the State submitted all sources of non-Federal share funding to be used to access the LIP funding to CMS for approval. The sources of the non-Federal share must comply with all Federal statutes and regulations. On March 16, 2006, CMS requested additional information of these sources and the Agency submitted a revised source of non-Federal share funding to be used to access the LIP funding to CMS on April 7, 2006.

On May 26, 2006, the Agency submitted the Reimbursement and Funding Methodology document for LIP expenditures, definition of expenditures eligible for Federal matching funds under the LIP and entities eligible to receive reimbursement. CMS requested additional information, and the Agency submitted a revised Reimbursement and Funding Methodology document that included the additional information on June 26, 2006.

On June 27, 2006, Florida submitted a State Plan Amendment (SPA) # 06-006 to CMS to terminate the current inpatient supplemental payment upper payment limit (UPL) program effective July 1, 2006, or such earlier date specific to the implementation of this demonstration. Also, this SPA limited the inpatient hospital payments for Medicaid eligibles to Medicaid cost as defined in the CMS 2552-96. In the event of termination of the Florida Medicaid 1115 Demonstration Waiver, the State may submit a new State Plan Amendment reinstituting inpatient hospital supplemental payments. The State has agreed not to establish any new inpatient or outpatient UPL programs for the duration of the demonstration.

On June 30, 2006, the Agency received confirmation from CMS stating that "as of July 1, 2006, the State of Florida is permitted to make expenditures from the Low Income Pool (LIP) in accordance with the Special Terms and Conditions (STCs) approved October 19, 2005."

Current Activities

On June 24, 2009, the Agency submitted to CMS an updated Reimbursement and Funding Methodology document that includes updated LIP expenditures and the definition of expenditures eligible for Federal matching funds under the LIP. This document is submitted as the final version of the Reimbursement and Funding Methodology document in accordance with STCs # 93, # 98 and #101a.

> **93. Reimbursement and Funding Methodology Document.** In order to define LIP permissible expenditures the State shall submit for

CMS approval a Reimbursement and Funding Methodology document for the LIP expenditures and LIP parameters defining State authorized expenditures from the LIP and entities eligible to receive reimbursement. This is further defined in Section XVI, "Low Income Pool."

98. Low Income Pool Permissible Non-Hospital Based Expenditures. To ensure services are paid at cost, CMS and the State will agree upon cost-reporting strategies and define them in the Reimbursement and Funding Methodology document for expenditures for non-hospital based services.

101a. Demonstration Year 1 Milestones. The State agrees that within 6 months of implementation of the demonstration it will submit a final document including CMS comments on the Reimbursement and Funding Methodology document (referenced in item 91).

2009 Legislation – Distribution of LIP Funds

The State of Florida's State Fiscal Year (SFY) 2009-2010 General Appropriations Act (GAA) and Senate Bill 2602, the Implementing Bill accompanying the GAA, included language that reduced the total budget authority of SFY 2008-2009 LIP distributions by $123,577,163. This change made the new total anticipated LIP distributions for SFY 2008-2009 $877,872,837. The 2009-2010 GAA provides that the sum of $123,577,163 in budget authority is provided to make payments to hospitals under the LIP Program. The distribution of the LIP funds for SFY 2009-2010 is contingent upon the Agency obtaining an amendment to the STCs of the Florida Medicaid Reform section 1115 demonstration that allows for the distribution of $1 billion in LIP distributions in the fifth year of the waiver (SFY 2010-2011). If the amendment to the demonstration is not approved by January 31, 2010, then the LIP funds shall be used in SFY 20010-2011 for the LIP Program as appropriated in the GAA for SFY 2010-2011.

The Agency has scheduled a conference call for July 15, 2009, with CMS-Central and Regional Offices to discuss the 2009 Legislation in GAA for SFY 2009-2010, related to the distribution of LIP funds (as described in the paragraph above). The Agency has sent an electronic copy of the 2009 session provisions to CMS staff in preparation for the call.

Successes in Florida FQHCs

The LIP funding has been instrumental in Florida's Federally Qualified Health Centers' (FQHCs) efforts to successfully expand services working with hospitals, county health departments, and other local organizations to serve Florida's uninsured and underinsured populations. Currently, there are 44 FQHCs operating in Florida that provide quality health care in more than 230 service locations. The service locations include eight County Health Departments who also operate an FQHC. The LIP funds have assisted in an increase of nearly 22% in new FQHC service locations beginning in

SFY 2006-2007. Allowing for a dramatic rise in the number of homeless patients being serviced (12%), the LIP funds has also allowed for a continued growth in the number of clinical providers in FQHCs throughout Florida. Twenty FQHCs are developing or have established ER Diversion Programs with partner hospitals throughout Florida. The ER Diversion Programs are instrumental in elevating the overutilization of hospital emergency departments and delivering cost efficient primary health care.

The following is a brief overview of the activities undertaken by Florida's FQHCs with funding provided from the LIP Program during SFY 2008-2009.

- **Tampa Family Health Centers** has added a full time diabetic educator; after-hours services five days a week at several sites; opened new pharmacy services at West Waters Health Center; and opened an Urgent Care Center at Lee Davis Neighborhood Center. Tampa Family Health Centers added 1,337 new patients in the last year. Of the new patients added, 815 are uninsured. In July 2008, Tampa Family Health Centers opened the Urgent Care Center that was designed to reduce ER utilization and provide a medical home for patients that have relied on an ER as their source of primary care. The Urgent Care Center is open fourteen hours a day, Monday through Friday, and ten hours on Saturdays.

- **Premier County Health Care** located in Pasco County increased their hours of operation, and is now open 8am-8pm on Saturdays allowing for access to primary care outside of the normal business hours. Premier County Health Care also opened an additional site to allow for greater access to primary care. This new site is located across the street from North Bay Hospital and operates an ER diversion program while simultaneously establishing a medical home for uninsured and Medicaid patients.

- **The Sulzbacher Center** located in Duval County offers street-based medical treatment and mental health treatment for the homeless population in Jacksonville. The Sulzbacher Center has added 224 new patients, of which 213 are uninsured.

- **Escambia Community Clinics** located in Escambia County has added Women's Health Services as an additional service. LIP funds assisted the Escambia Community Clinic in adding three professional providers. The clinic has added more than 1,000 new patients and more than 50% are uninsured.

- **Collier Health Services** located in Collier County has added one additional provider, and has experienced nearly 4,300 extra visits for about 1,500 patients. The LIP funds are vital to the growing health care service needs as approximately 1,000 of the additional patients are uninsured and 350 have Medicaid coverage.

- **Manatee County Rural Health** located in Manatee County added a surgical physician services at a new location, added ER diversion services at two locations in two additional counties and expanded hours of operation to include evenings and weekends. This represents an additional 40 hours at each location. The Manatee

County Rural Health has also added a pediatric service location, a gastroenterology service provider, a podiatrist and optometry services at a new location.

- **Suncoast Community Health Center** located in Hillsborough County expanded pediatric services at the Dover location. In addition, the Suncoast Community Health Center added two professional health care providers, an ARNP and a dental hygienist. Suncoast Community Health Center added 7,890 new patients. Of the new patients, 2,840 are Medicaid recipients and 4,655 are uninsured. Suncoast Community Health Center is working with Brandon and South Bay hospitals to develop an ER diversion program.

- **Brevard Health Alliance** located in Brevard County now has an ER diversion program associated with two hospital systems, Halifax Health and Wuesthoff Hospital, which includes 200 appointments a month for walk in patients. Brevard Health Alliance also added three new physicians, and expanded the mobile health unit to six days a week. These services are critical to many low income patients where transportation is often a barrier to primary health care. The number of new patients served by the Brevard Health Alliance has grown by 25% in the past year. The Brevard Health Alliance reports registering 600 new patients a month, with 75% of the new patients uninsured and 10% receive Medicaid. The Alliance also expanded services to 22 Medicaid children in a foster care home.

- **Miami Beach Community Health Clinic (CHC)** in Dade County has added Chiropractic and Ophthalmology services. The Miami Beach CHC has added two Chiropractors; an Ophthalmologist and a Pediatrician. The Miami Beach CHC has added 1,437 new patients. Of the new patients, 207 patients receive Medicaid and 874 patients are uninsured.

G. Monitoring Budget Neutrality

Overview

In accordance with the requirements of the approved 1115 Medicaid Reform Demonstration Waiver, Florida must monitor the status of the program on a fiscal basis. To comply with this requirement, the State will submit waiver templates on the quarterly CMS 64 reports. The submission of the CMS 64 reports will include administrative and service expenditures. For purposes of monitoring the Budget Neutrality of the program, only service expenditures are compared to the projected without-waiver expenditures approved through the 1115 Medicaid Reform Waiver.

MEGS

There are three Medicaid Eligibility Groups established through the Budget Neutrality of the Medicaid Reform 1115 Waiver. Each of these groups is referred to as a MEG.

MEG #1 – SSI Related
MEG #2 – Children and Families
MEG #3 – Low Income Pool program

It should be noted that for MEG 3, the Low Income Pool, there is no specific eligibility group and no per capita measurement. Distributions of funds are made from the Low Income Pool to a variety of Provider Access Systems.

Explanation of Budget Neutrality

The Budget Neutrality for the 1115 Medicaid Reform Waiver is based on five closed years of historical data using paid claims for services provided to the eligible populations throughout the state. The data is compiled using a date of service method which is required for 1115 waivers. Using the templates provided by the Centers for Medicare and Medicaid Services, the historical expenditures and case-months are inserted into the appropriate fields. The historical data template is pre-formulated to calculate the five year trend for each MEG. This trend is then applied to the most recent year (5^{th} year), which is known as the base year, and projected forward through the waiver period. Additional negotiations were involved in the final Budget Neutrality calculations set forth in the approved waiver packet.

The 1115 Medicaid Reform Waiver is a program that provides all services to the specified populations. If a person is eligible for the waiver, he or she is eligible to receive all services that would otherwise be available under the traditional Medicaid program. There are a few services and populations excluded from the 1115 Medicaid Reform Waiver.

To determine if a person is eligible for the 1115 Medicaid Reform Waiver, the first step is identifying his or her eligibility category. Each person who applies for and is granted Medicaid eligibility is assigned an eligibility category by the Florida Department of

Children and Families. Specific categories are identified for each MEG under the 1115 Medicaid Reform Waiver. If the person has one of the identified categories and is not an excluded eligible, he or she is then flagged as eligible for the 1115 Medicaid Reform Waiver. Dual eligibles and pregnant women above the TANF eligibility may voluntarily enroll in a Medicaid Reform health plan. All voluntary enrollment member months and expenditures subject to the 1115 Medicaid Reform Waiver are included in the reporting and monitoring of Budget Neutrality of the waiver.

Excluded Eligibles:

- Refugee Eligibles
- Dual Eligibles
- Medically Needy
- Pregnant Women above the TANF eligibility (>27% FPL, SOBRA)
- ICF/DD Eligibles
- Unborn Children
- State Mental Facilities (Over Age 65)
- Family Planning Eligibles
- Women with breast or cervical cancer
- MediKids

All expenditures for the flagged eligibles are subject to the Budget Neutrality of the 1115 Medicaid Reform Waiver unless the expenditure is identified as one of the following excluded services. These services are specifically excluded from the 1115 Medicaid Reform Waiver and the Budget Neutrality calculation.

Excluded Services:

- AIDS Waiver Services
- DD Waiver Services
- Home Safe Net (Behavioral Services)
- Behavioral Health Overlay Services (BHOS)
- Family and Supported Living Waiver Services
- Katie Beckett Model Waiver Services
- Brain and Spinal Cord Waiver Services
- School Based Administrative Claiming
- Healthy Start Waiver Services

Expenditure Reporting:

The 1115 Medicaid Reform Waiver requires the Agency to report all expenditures on the quarterly CMS 64 report. Within the report, there are specific templates designed to capture the expenditures by service type paid during the quarter that are subject to the monitoring of the Budget Neutrality. There are three MEGs within the 1115 Medicaid

Reform Waiver. MEGs 1 and 2 are statewide populations, and MEG 3 is based on Provider Access Systems. Under the design of Florida Medicaid Reform, there is a period of transition in which eligibles continue to receive services through Florida's 1915(b) Managed Care Waiver programs. The expenditures for those not enrolled in the 1115 Medicaid Reform Waiver but eligible for Medicaid Reform and enrolled in Florida's 1915(b) Managed Care Waiver are subject to both the monitoring of the 1915(b) Managed Care Waiver and the 1115 Medicaid Reform Waiver. To identify these eligibles, an additional five templates (one for each of the 1915(b) Managed Care Waiver MEGs) have been added to the 1115 Medicaid Reform Waiver templates for monitoring purposes.

When preparing for the quarterly CMS 64 report, the following method is applied to extract the appropriate expenditures for MEGs 1 and 2:

I. Eligibles and enrollee member months are identified;

II. Claims data for included services are identified using the list created through 'I' above;

III. The claims data and member months are separated into appropriate categories to report on the waiver forms of the CMS 64 report:
   a. MEG #1 SSI- Related
   b. MEG #2 Children and Families
   c. Reform – Managed Care Waiver SSI – no Medicare
   d. Reform – Managed Care Waiver TANF
   e. Reform – Managed Care Waiver SOBRA and Foster Children
   f. Reform – Managed Care Waiver Age 65 and Older

IV. Using the paid claims data extracted, the expenditures are identified by service type within each of the groupings in 'III' above and inserted on the appropriate line on the CMS 64 waiver templates;

V. Expenditures that are also identified as Home and Community Based (HCBS) Waiver services are identified and the corresponding HCBS waiver template expenditures are adjusted to reflect the hierarchy of the 1115 waiver reporting.

All queries and work papers related to the quarterly reporting of waiver expenditures on the CMS 64 report are maintained by the Agency. In addition, all identified expenditures for waiver and non-waiver services in total are checked against expenditure reports that are generated and provided to the Agency's Finance and Accounting unit which certifies and submits the CMS 64 report. This check sum process allows the state to verify that no expenditures are being duplicated within the multiple templates for waiver and non-waiver services.

Statistics tables below show the current status of the program's Per Capita Cost per Month (PCCM) in comparison to the negotiated PCCM as detailed in the Special Terms and Conditions (STC #116).

Definitions:

- **PCCM** - Calculated per capita cost per month which is the total spend divided by the case months.
- **WOW PCCM** - Is the without waiver PCCM. This is the target that the state cannot exceed in order to maintain Budget Neutrality.
- **Case months** - The months of eligibility for the populations subject to the waiver as defined as included populations in the waiver. In addition, months of eligibility for voluntary enrollees during the period of enrollment within a Medicaid Reform health plan are also included in the case month count.
- **MCW Reform Spend -** Expenditures subject to the Reform Budget Neutrality for those not enrolled in a Reform Health Plan but subject to the Reform Waiver (currently all non dual-eligibles receiving services through the 1915(b) Managed Care Waiver).
- **Reform Enrolled & Non-MCW Spend** - Expenditures for those enrolled in a Reform Health Plan.
- **Total Spend** - Total of MCW Reform Spend and Reform Enrolled Spend.

The quarterly totals may not equal the sum of the monthly expenditure data due to adjustments for disease management programs, rebates and other adjustments which are made on a quarterly basis. Without the adjustment of drug rebates, the quarterly expenditure reform totals match the corresponding quarterly CMS 64 Report submission, which details the amount that will be used in the monitoring process by the Centers for Medicare and Medicaid Services.

Current Activities

The 1115 Medicaid Reform Waiver is budget neutral as required by the STCs of the waiver. In accordance with the monitoring and reporting requirements of 1115 demonstration waivers, the Budget Neutrality is tracked by each demonstration year.

Budget Neutrality is calculated on a statewide basis. For counties where the demonstration is operating, the case months and expenditures reported are for enrolled mandatory and voluntary individuals. For counties where the demonstration is not operational, the mandatory population and expenditures are captured and subject to the budget neutrality. However, these individuals receive their services through the Medicaid State Plan, the providers of the 1915(b) Managed Care Waiver and / or providers of 1915(c) Home and Community Based Waivers.

Although this report will show the quarterly expenditures for the quarter in which the expenditure was paid (date of payment), the Budget Neutrality as required by STC #108 is monitored using data based on date of service. The PMPM and demonstration years are tracked by the year in which the expenditure was incurred (date of service). The STCs specify that the Agency will track case months and expenditures for each demonstration year using the date of service for up to two years after the end of the demonstration year.

The expenditures in the following tables do not match the expenditures reported on the CMS 64 report for the quarter ending June 30, 2009. The CMS 64 report included an expenditure run with a date of payment of July 1, 2009, for services with dates of payment beginning July 1, 2009, which is the beginning of Demonstration Year 4. The total reported on the June 30, 2009, CMS 64 report is $194,690,585 for Demonstration Year 4. This amount includes $83,120,812 for MEG 1 and $111,569,773 for MEG 2. These amounts will be included on the next Quarterly Report.

In the following tables (Tables 29 through 34), both date of service and date of payment data are presented. Tables that provide data on a quarterly basis reflect data based on the date of payment for the expenditure. Tables that provide annual or demonstration year data are based on the date of service for the expenditure.

Table 29 shows the PCCM Targets established in the 1115 Medicaid Reform Waiver as specified in STC #116. These targets will be compared to actual waiver expenditures using date of service tracking and reporting.

Table 29
PCCM Targets

WOW PCCM	MEG 1	MEG 2
DY01	$ 948.79	$ 199.48
DY02	$ 1,024.69	$ 215.44
DY03	$ 1,106.67	$ 232.68
DY04	$ 1,195.20	$ 251.29
DY05	$ 1,290.82	$ 271.39

Tables 30 through 34 provide the statistics for MEGs 1, 2, and 3 for the period beginning July 1, 2006, and ending June 30, 2009. Case months provided in the Tables 30 and 31 for MEGs 1 and 2 are actual eligibility counts as of the last day of each month. The expenditures provided are recorded on a cash basis for the month paid.

Table 30
MEG 1 Statistics: SSI Related

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 1	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**737,829**	**$534,465,763**	**$13,022,287**	**$547,488,050**	**$742.03**
Q2 Total	**741,024**	**$656,999,737**	**$40,270,607**	**$697,270,344**	**$940.96**
Q3 Total	**746,739**	**$627,627,027**	**$74,363,882**	**$701,990,909**	**$940.08**
Q4 Total	**752,823**	**$627,040,703**	**$98,024,915**	**$725,065,618**	**$963.13**
Q5 Total	**755,417**	**$630,937,251**	**$101,516,732**	**$732,453,983**	**$969.60**
Q6 Total	**755,837**	**$648,757,106**	**$106,374,845**	**$755,131,951**	**$999.07**
Q7 Total	**758,014**	**$651,490,311**	**$112,015,041**	**$763,505,352**	**$1,007.24**
Q8 Total	**764,701**	**$661,690,100**	**$115,119,581**	**$776,809,682**	**$1,015.83**
Q9 Total	**818,560**	**$708,946,109**	**$116,915,711**	**$825,861,820**	**$1,008.92**
Q10 Total	**791,043**	**$738,232,869**	**$128,483,862**	**$866,716,731**	**$1,095.66**
Q11 Total	**810,753**	**$783,046,121**	**$125,741,442**	**$908,787,564**	**$1,120.92**
April 2009	279,520	$228,078,131	$40,285,682	$268.363,814	$960.09
May 2009	276,496	$164,673,989	$33,982,793	$198,656,782	$718.48
June 2009	273,370	$283,629,455	$46,730,602	$330,360,057	$1,208.47
Q12 Total	**829,386**	**$676,381,576**	**$120,999,077**	**$797,380,652**	**$961.41**
MEG 1 Total	**9,262,126**	**$7,945,614,674**	**$1,152,847,983**	**$9,098,462,656**	**$982.33**

* Quarterly expenditure totals may not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 Report submissions without the adjustment of rebates.

Table 31
MEG 2 Statistics: Children and Families

Quarter		MCW Reform	Reform Enrolled		
Actual MEG 2	**Case months**	**Spend***	**Spend***	**Total Spend***	**PCCM**
Q1 Total	**3,944,437**	**$491,214,740**	**$1,723,494**	**$492,938,235**	**$124.97**
Q2 Total	**3,837,172**	**$590,933,703**	**$21,021,285**	**$611,954,988**	**$159.48**
Q3 Total	**3,728,063**	**$559,579,323**	**$44,697,737**	**$604,277,060**	**$162.09**
Q4 Total	**3,653,147**	**$524,161,918**	**$57,096,383**	**$581,258,301**	**$159.11**
Q5 Total	**3,588,363**	**$520,316,242**	**$57,360,334**	**$577,676,576**	**$160.99**
Q6 Total	**3,648,832**	**$553,763,665**	**$63,871,154**	**$617,634,819**	**$169.27**
Q7 Total	**3,736,212**	**$570,477,394**	**$69,992,290**	**$640,469,684**	**$171.42**
Q8 Total	**3,856,584**	**$564,601,990**	**$70,899,271**	**$635,501,261**	**$ 164.78**
Q9 Total	**4,080,307**	**$586,455,736**	**$70,031,931**	**$656,487,667**	**$160.89**
Q10 Total	**4,174,698**	**$659,100,473**	**$71,936,704**	**$731,037,178**	**$175.11**
Q11 Total	**4,298,379**	**$708,620,481**	**$73,835,227**	**$782,455,708**	**$182.04**
April 2009	1,500,924	$209,199,849	$23,128,461	$232,328,310	$154.79
May 2009	1,521,314	$117,999,983	$10,771,173	$128,771,156	$84.64
June 2009	1,519,218	$253,830,966	$26,922,880	$280,753,846	$184.80
Q12 Total	**4,541,456**	**$581,030,798**	**$60,822,514**	**$641,853,312**	**$141.33**
MEG 2 Total	**47,087,650**	**$6,910,256,464**	**$663,288,326**	**$7,573,544,790**	**$160.84**

* Quarterly expenditure totals may not equal the sum of the monthly expenditures due to quarterly adjustments such as disease management payments. The quarterly expenditure totals match the CMS 64 Report submissions without the adjustment of rebates.

For Demonstration Year One, MEG 1 has a PCCM of $972.13 (Table 32), compared to WOW of $948.79 (Table 29), which is 102.46% of the target PCCM for MEG 1. MEG 2 has a PCCM of $160.23 (Table 32), compared to WOW of $199.48 (Table 29), which is 80.32% of the target PCCM for MEG 2.

For Demonstration Year Two, MEG 1 has a PCCM of $1,013,31 (Table 32), compared to WOW of $1,024.69 (Table 29), which is 98.89% of the target PCCM for MEG 1. MEG 2 has a PCCM of $169.30 (Table 32), compared to WOW of $215.44 (Table 29), which is 78.59% of the target PCCM for MEG 2.

For Demonstration Year Three, MEG 1 has a PCCM of $962.75 (Table 32), compared to WOW of $1,106.67 (Table 29), which is 87.00% of the target PCCM for MEG 1. MEG 2 has a PCCM of $154.04 (Table 32), compared to WOW of $232.68 (Table 29), which is 66.20% of the target PCCM for MEG 2.

Tables 31 and 33 provide cumulative expenditures and case months for the reporting period for each demonstration year. The combined PCCM is calculated by weighting MEGs 1 and 2 using the actual case months. In addition, the PCCM targets as provided in the STCs are also weighted using the actual case months.

For Demonstration Year One, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $322.50. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $293.53. Comparing the calculated weighted averages, the actual PCCM is 91.02% of the target PCCM.

For Demonstration Year Two, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $352.88. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $312.65. Comparing the calculated weighted averages, the actual PCCM is 88.60% of the target PCCM.

For Demonstration Year Three, the weighted target PCCM for the reporting period using the actual case months and the MEG specific targets in the STCs (Table 33) is $372.29. The actual PCCM weighted for the reporting period using the actual case months and the MEG specific actual PCCM as provided in Table 33 is $283.22. Comparing the calculated weighted averages, the actual PCCM is 76.08% of the target PCCM.

Table 32
MEG 1 & 2 Annual Statistics

DY01 – MEG 1	Actual CM	Actual Spend MCW & Reform Enrolled		Total	PCCM
MEG 1 - DY01 Total	2,978,415	$2,631,566,388	$263,851,544	$2,895,417,932	$972.13
WOW DY1 Total	2,978,415			$2,825,890,368	$948.79
Difference				$69,527,564	
% of WOW PCCM MEG 1					102.46%
DY01 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY01 Total	15,162,819	$2,293,656,191	$135,864,711	$2,429,520,901	$160.23
WOW DY1 Total	15,162,819			$3,024,679,134	$199.48
Difference				$(595,158,233)	
% of WOW PCCM MEG 2					80.32%
DY02 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY02 Total	3,033,969	$2,632,920,981	$441,425,660	$3,074,346,641	$1,013.31
WOW DY2 Total	3,033,969			$3,108,877,695	$1,024.69
Difference				$(34,531,053)	
% of WOW PCCM MEG 1					98.89%
DY02 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY02 Total	14,829,991	$2,246,768,250	$264,010,165	$2,510,778,415	$169.30
WOW DY2 Total	14,829,991			$3,194,973,261	$215.44
Difference				$(684,194,846)	
% of WOW PCCM MEG 2					78.59%
DY03 – MEG 1	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 1 - DY03 Total	3,249,742	$2,681,127,304	$447,570,779	$3,128,698,083	$962.75
WOW DY3 Total	3,249,742			$3,596,391,979	$1,106.67
Difference				$(467,693,896)	
% of WOW PCCM MEG 1					87.00%
DY03 – MEG 2	**Actual CM**	**Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
MEG 2 - DY03 Total	17,094,840	$2,369,832,024	$263,413,450	$2,633,245,474	$154.04
WOW DY3 Total	17,094,840			$3,977,627,371	$232.68
Difference				$(1,344,381,897)	
% of WOW PCCM MEG 2					66.20%

Table 33
MEG 1 & 2 Cumulative Statistics

DY 01	Actual CM	MEG 1 & 2 Actual Spend MCW & Reform Enrolled		Total	PCCM
Meg 1 & 2	18,141,234	$4,925,222,579	$399,716,255	$5,324,938,833	$293.53
WOW	18,141,234			$5,850,569,502	$322.50
Difference				$(525,630,669)	
% Of WOW					91.02%
DY 02	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	17,863,960	$4,879,689,231	$705,435,825	$5,585,125,056	$312.65
WOW	17,863,960			$6,303,850,956	$352.88
Difference				$(718,725,900)	
% Of WOW					88.60%
DY 03	**Actual CM**	**MEG 1 & 2 Actual Spend MCW & Reform Enrolled**		**Total**	**PCCM**
Meg 1 & 2	20,344,582	$5,050,959,328	$710,984,229	$5,761,943,557	$283.22
WOW	20,344,582			$7,574,019,350	$372.29
Difference				$(1,812,075,794)	
% Of WOW					76.08%

Table 34
MEG 3 Statistics: Low Income Pool

MEG 3 LIP	Paid Amount
Q1	$1,645,533
Q2	$299,648,658
Q3	$284,838,612
Q4	$380,828,736
Q5	$114,252,478
Q6	$191,429,386
Q7	$319,005,892
Q8	$329,734,446
Q9	$165,186,640
Q10	$226,555,016
Q11	$248,152,977
Q12	$178,992,988
Total Paid	$2,740,271,362

DY*	Total Paid	DY Limit	% of DY Limit
DY01	$998,806,049	$1,000,000,000	99.88%
DY02	$999,632,926	$1,000,000,000	99.96%
DY03	$741,832,387	$1,000,000,000	74.18%
Total MEG 3	$2,740,271,362	$5,000,000,000	54.81%

*DY totals are calculated using date of service data as required in STC #108.

The expenditures for the first twelve quarters for MEG 3, the Low Income Pool (LIP), were $2,740,271,362 (54.81% of the $5 billion cap).

H. Encounter and Utilization Data

Overview

The Agency is required to capture medical services encounter data for all Medicaid-covered services in compliance with Title XIX of the Social Security Act, the Balanced Budget Act of 1997, 42 CFR 438, and Chapters 409 and 641, Florida Statutes. In addition, 409.91211(3)(p), Florida Statutes, requires a risk-adjusted methodology be a component of the rate setting process for capitated payments to Reform health plans. Risk adjustment is to be phased in over a period of three years, beginning with the Medicaid Rx model and transitioning to a diagnosis-based model such as the Chronic Illness and Disability Payment System (CDPS) in the near future.

The Medicaid Encounter Data System / Risk Adjustment Team (MEDS Team) is comprised of internal subject matter experts and external consultants with experience in the risk adjustment and medical encounter data collection processes. The MEDS Team continues to support the implementation and operational activities of the Medicaid Encounter Data System.

Current Activities

During the quarter April 1, 2009, through June 30, 2009, the Agency continued collecting and verifying encounter data from all capitated health plans on a statewide basis for all Medicaid covered services. There are two collection efforts occurring concurrently: the collection of encounter data for all Medicaid covered services within the Florida Medicaid Management Information System (FMMIS), and the collection of quarterly pharmacy encounter data for risk adjustment purposes.

As reported last quarter, HMOs remain in various states of readiness to submit encounter claims to the Agency. PSNs remain in various states of readiness to submit transportation encounter claims. The Agency started processing production encounter data on a limited basis through the new FMMIS this quarter.

The following are the highlights for this quarter:

- Continued testing activities associated with the new FMMIS under EDS to support encounter data collection and processing. This included weekly meetings with Medicaid leadership to track the progress of several system change orders necessary to encounter data processing and back-end reporting.
- Collected and processed a limited number of production encounter data files through the new FMMIS.
- Continued ongoing efforts with the health plans, the Fiscal Agent (EDS), and the Pharmacy Benefits Manager (First Health) to coordinate the collection of pharmacy and medical services encounter data within the new FMMIS using the HIPAA compliant formats (X12 and NCPDP).

- Notified the health plans that encounter data resubmission will begin in July 2009 for both historical and current encounter data. Historical encounter data include all medical services encounter data for paid dates January 1, 2007, through June 30, 2009, and all pharmacy encounter data for paid dates July 1, 2008 through June 30, 2009. Current encounter data include all medical services and pharmacy encounter data for paid dates beginning July 1, 2009.
- Continued to update the MEDS website, including the maintenance of relevant information used to facilitate communications with the health plans including MEDS and NCPDP Companion Guides, Data Submission Strategy Guidelines, X12 EDI Transaction Encounter Claims Exception Reporting, and MEDS FTP Site Instructions.
- Participated in encounter data submission meetings with each health plan to discuss submission specifics and address their potential issues and concerns. Also participated in biweekly technical and operations calls with the plans to respond to questions and technical issues.
- Developed a SQL Server environment to allow the team to begin analysis of the historical encounter data as quickly as possible. These encounter data will assist in determining if "under-reporting" is occurring and track encounter volume and PMPM by plan by service.
- Continued to test and refine reports and HIPAA-compliant Electronic Data Interchange (EDI) processes used to communicate various operational errors and invalid transaction content to health plans for remediation of identified encounters failing FMMIS edits.
- Worked with the Fiscal Agent to refine the Medicaid Decision Support System (DSS) to support data quality validation through analysis of the volume, accuracy, and completeness of encounter data submitted.
- Held weekly update meetings for Medicaid management specific to progress of the Agency and the health plans in the receipt and submission of encounter data.
- Conducted weekly MEDS Team meetings to discuss project progress, risks, and issues that needed to be addressed to keep us on track.
- Initiated planning for the Agency Encounter Data Utilization Team, to provide inter-bureau input to the MEDS Team by developing and prioritizing uses for the MEDS data after implementation.

During the quarter, to comply with the requirements of the demonstration waiver, health care pharmacy encounter data and Medicaid enrollee information were collected and processed for the calculation of individual risk scores for both the fee-for-service and managed-care Medicaid populations. Using the Medicaid Rx model, the health plans were assigned plan risk factors for both TANF and SSI based on the aggregate risk scores of their enrolled populations in those categories under the demonstration.

Health plan factors, budget neutrality and the derived risk corridor plan factor have been applied to capitated premium rates beginning in October 2006 and for each subsequent month thereafter for Medicaid-enrolled populations in Reform counties. As mentioned in previous reports, Legislation required that capitation premiums be fully risk adjusted and health plan corridor factors were no longer to be applied effective with Year Three of the demonstration.

The most recent 12-month measurement period used in the Medicaid Rx methodology for risk adjusting Reform capitation rates was October 1, 2007, through September 30, 2008, paid through December 31, 2008. This measurement period was used to generate risk adjustment factors for the health plans operating in the five demonstration counties.

The following are the highlights for this quarter regarding the collection, validation, and utilization of quarterly pharmacy encounter data for risk adjustment purposes:

- Continued to collect and process pharmacy encounter data on a quarterly basis from capitated health plans operating in all counties in Florida. These data are validated, and any significant changes from the previous quarter's submission are reported to the health plans for corrective action, if necessary.
- Halted testing of the CDPS risk adjustment model to evaluate the feasibility of using medical and diagnosis code data because the Medicaid Rx model developer is implementing logic changes. Updates to the Medicaid Rx Model include drug classifications and incorporation of recently introduced drugs into the model, among others. The update will require new cost weights to be implemented for the Medicaid Rx Model in Florida. When updates to the model are completed, encounter data collected through FMMIS may be utilized for the testing instead of data that was collected for risk adjustment.
- For this period, risk adjustment plan factors were calculated for the following health plans:

Access Health Solutions	Humana	Shands Jacksonville
Amerigroup	SFCCN – Memorial Healthcare System	StayWell
Children's Medical Services	NetPass	Total Health Choice
Freedom Health Plan	SFCCN – North Broward Hospital Districts	Universal Health Care
HealthEase	Preferred Medical Plan	

Note: Effective July 1, 2009, Staywell and HealthEase will no longer participate in the demonstration as described in Section A of this report.

- The demonstration enrollment that is subject to risk adjustment using the Medicaid Rx model does not include the 'Under 1 year old' population, or specialty plans/populations such as HIV/AIDS and CMS. Enrollment for risk adjustment

purposes in the demonstration counties for the month of June 2009 totaled 203,299 and was distributed as follows:

March 2009	Broward	Duval, Baker, Clay, and Nassau
Children & Families	95,012	81,072
SSI	15,189	12,026
Totals	**110,201**	**93,098**

- Pharmaceutical data will continue to be collected and processed through Medicaid Rx to support risk adjustment capitation rate premium calculations until encounter data for all services are collected in the FMMIS and are of sufficient quality and completeness for a transition to a diagnostic risk-adjustment model such as CDPS.

The process of providing plan risk factors for Medicaid Reform rate setting and budget neutrality will continue into the next quarter. Scheduled activities in the MEDS project plan associated with the collection and processing of encounters will also continue. These activities include providing technical support to capitated health plans, reviewing end-to-end processing results, reporting on encounter submission adjudication results, and the creation and dissemination of operational documentation to support MEDS ongoing collection, validation and utilization of both historical and current encounter data.

I. Demonstration Goals

Medicaid Reform is fundamentally changing the current Florida Medicaid program. For this reason, the state is very interested in evaluating the impact of Medicaid Reform, and anticipates using the evaluation as a means to inform policy decisions in both the short and long term. As lessons are learned on an incremental basis, these data will be used to shape further geographic expansion within the five-year demonstration, as well as evaluate the impact of the full five-year implementation. There are six (6) key design elements of Medicaid Reform tracked by the Agency in order to evaluate progress towards achieving its goals. These objectives are specified in the approved 1115 Medicaid Reform Waiver. Information about each key evaluation objective is below.

Objective 1: *To ensure there is an increase in the number of plans from which an individual may choose; an increase in the different type of plans; and increased patient satisfaction.*

Prior to the implementation of Medicaid Reform, the Agency contracted with various managed care programs including: eight HMOs, one PSN, one Pediatric Emergency Room Diversion Program, two Minority Physician Networks (MPNs), for a total of twelve managed care programs in Broward County; and two HMOs and one MPN, for a total of three managed care programs in Duval County. The Pediatric Emergency Room Diversion and Minority Physician Networks that operated in Broward and Duval Counties prior to implementation of Medicaid Reform operated as prepaid ambulatory health plans offering enhanced medical management services to beneficiaries enrolled in MediPass, Florida's primary care case management program.

The Agency currently has contracts with 9 HMOs and 5 PSNs for a total of 14 Reform health plans in Broward County; and 4 HMOs and 3 PSNs for at total of 7 Reform health plans in Duval County. As noted in Section A of this report, United Health Plan, Vista, and Vista Health Plan of South Florida ceased operations in Broward County during the second quarter of Year Three. The health plans stated reasons for pulling out of these counties was not specific to the demonstration or to the September 1, 2008, capitation rates; rather the plans stated their withdrawal was related to network provider contracting issues. Third quarter of Year Three, two HMOs, Staywell and HealthEase notified the Agency of their intent to cease operations in the demonstration area effective July 1, 2009. Both health plans are owned by parent company, Wellcare. Wellcare's stated reasons for pulling out of these counties were not specific to the demonstration but instead were related to the legislated March 1, 2009, capitation rate reduction. See Section A of the report for detailed information about the HealthEase and Staywell transition process.

Since the beginning of the demonstration, the Agency has received 22 health plan applications (15 HMOs and 7 PSNs) of which 20 applicants sought and received approval to provide services to the TANF and SSI population. Of the 22 health plan applications received, all but two were approved as health plans as of June 30, 2009.

The most recent application was received January 14, 2009, from Sunshine State Health Plan, an HMO. Sunshine State Health Plan was approved in May 2009, with its first enrollment scheduled for July 2009. In addition, Sunshine State Health Plan has requested to expand into Baker, Clay and Nassau Counties.

The two health plan applications still pending were submitted by HMOs: AIDS Healthcare Foundation, Inc., a specialty plan (HMO) for beneficiaries living with HIV/AIDS, and Medica Health Plans of Florida. AIDS Healthcare Foundation, Inc., doing business as Positive Health Care, submitted its application in January 2008 to serve beneficiaries living with HIV/AIDS. This application is the second specialty plan application the Agency has received (the first being the specialty plan for children with chronic conditions which became operational in 2006). As of June 30, 2009, this specialty plan application was nearing completion of Phase III of the application process. Medica Health Plans of Florida is an HMO with a national base. As of June 30, 2009, this HMO application was in Phase II of the application process.

Patient satisfaction was also examined and is addressed in objective 5.

Objective 2: *To ensure that there is access to services not previously covered and improved access to specialists.*

Access to Services Not Previously Covered

All of the capitated health plans offered expanded or additional benefits which were not previously covered by the State under the Medicaid State Plan. For Year Three of the demonstration, the most popular expanded benefits offered by the capitated plans were over-the-counter (OTC) drug benefits and adult preventive dental benefits. The expanded services available to beneficiaries in Year Three include:

- Over-the-counter drug benefit from $20 to $25 per household, per month;
- Adult Preventative Dental;
- Circumcisions for male newborns;
- Acupuncture;
- Additional Adult Vision - up to $125 per year for upgrades such as scratch resistant lenses;
- Additional Hearing – up to $500 per year for upgrades to digital, canal hearing aid;
- Respite care; and
- Nutrition Therapy.

In Year Three, the Agency approved 28 customized benefit packages for the HMOs and 14 different expanded benefits for the FFS PSNs. The customized benefit packages and expanded benefits were effective for the contract period of November 1, 2008 to August 31, 2009 for 11 HMOs and 6 PSNs. In the third quarter of Year Three of the demonstration two HMOs, Buena Vista and Vista South Florida, and one PSN, Pediatric Associates), ceased operations in the demonstration areas. As a result, there were 24 customized benefit packages approved for 9 HMOs and 12 for the remaining 5 PSNs at

the beginning of the fourth quarter of Year Three. Throughout this reporting quarter, recipients enrolled in the demonstration plans Staywell and HealthEase have been transitioning to other health plans due to their withdrawal from the demonstration. This transition is expected to be completed July 1, 2009 and will not reduce the number of services not previously covered.

Improving Access to Specialists

The demonstration is designed to improve access to specialty care for beneficiaries. Through the contracting process, each health plan is required to provide documentation to the Agency of a network of providers (including specialists) that will guarantee access to care for beneficiaries. As Year One of the demonstration ended, the Agency had begun the first intensive review of the health plan provider network files to evaluate the effectiveness of the demonstration in improving access to specialists. The analysis includes the following steps:

1. Identifying the number of unduplicated providers that participate in Reform;
2. Identifying providers that were not fee-for-service providers, but now serve beneficiaries as a part of Reform;
3. Comparison of plan networks that were operational prior to Reform with the Reform health plan networks at the end of Year One of the waiver; and
4. Comparison of Reform provider networks to the active fee-for-service providers.

During the second quarter of Year Two, the Agency began additional provider network analysis of the Medicaid health plans, including each Medicaid Reform health plan. Beginning in October 2007, the Agency directed all Medicaid health plans to update their web-based and paper provider directories and to certify the provider network files that they submit to the Agency on a monthly basis. In addition to listing the providers' types and specialties, these provider network files must include any restrictions on recipient access to providers (e.g., if the provider only accepts current patients, or if they only treat children and women, etc.).

Also in October 2007, the Agency did some preliminary analyses of access to specialty care in Duval County based on the provider network files that health plans had submitted. Five specialties – Pain Management, Dental, Orthopedics, Neurology, and Dermatology – were identified by the Florida Medicaid Area Offices as areas of potential concern regarding access to care. The Agency compared health plans and active FFS providers in Duval County pre-Reform with the post-Reform health plan networks. Table 35 shows the results of these analyses.

Table 35
Results of Analyses of Access to Specialty Care in Duval County (Pre and Post-Reform)

	Pre-Reform (June 2006)						Post-Reform (June 2007)		Adequacy Benchmarks	
	Health Plan Count	Plan Specs per 100K	Active FFS Count	FFS Specs per 100K	Unique Count	**Specs per 100K**	Health Plan Count	**Specs per 100K**	**Estimate of Need per 100k (Low)**	**Estimate of Need per 100k (High)**
Pain Mgmt	2	4.9	143	351.3	145	**178.1**	58	**84.0**	**1.2**	**10.6**
Dermatology	3	7.4	3	7.4	6	**7.4**	9	**13.0**	**0.7**	**2.9**
Neurology	21	51.6	44	108.1	54	**66.3**	67	**97.0**	**1.2**	**3.4**
Orthopedics	32	78.6	31	76.2	48	**58.9**	64	**92.7**	**1.5**	**7.7**
General Dentistry	14	34.4	32	78.6	45	**55.3**	31	**44.9**	**17.5**	**30.8**
	Recipients: 40,721		Recipients: 40,709		Recipients: 81,430		Recipients: 69,056			

After factoring in estimates of need for each specialty, the Agency concluded that access to care for the five identified specialties in Duval County has either improved under Medicaid Reform or is more than adequate to meet recipient needs based on national benchmarks.

In November 2007, Agency staff began to improve the process of validating the accuracy of the health plans' provider network files. The Agency worked with contractors to create a survey tool aimed at measuring whether providers are indeed under contract with the health plans that report them as part of the health plan's networks and if so, whether the providers' restrictions match those reported in the health plan files. Agency staff members were trained to use this survey tool to call provider offices and verify provider participation and restrictions in Medicaid health plans.

In December 2007, the Agency pulled a random sample of 713 providers; 39 from each health plan's provider network file that was submitted to the Agency. This sample was split up between 21 Agency staff members, who conducted the surveys in the middle of the month. Of the 713 providers in the sample, 58.5% participated in the survey. Of those who participated, 84.4% of the providers confirmed participation in the health plans. Agency staff followed up with the health plans to see if they had a provider contract on file for those providers whose office managers did not confirm participation. This follow-up resulted in a finding that 99% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

During the second half of Year Two, the Agency finished analyzing the March 2008 and April 2008 survey data and continued to conduct surveys. In each month, the Agency pulled a sample of 300 providers across the state, 15 from each health plan, to be surveyed. Additionally, a geographic sample of 117 providers, 39 of each provider type (PCP, Individual Practitioner, and Dentist) was pulled from Area 10 (Broward County) in March 2008 and from Area 4 (Duval, Baker, Clay, Nassau, St. Johns, Flagler, and Volusia counties) in April 2008.

In the March 2008 statewide survey, 258 of the 300 providers were surveyed or could not be surveyed due to inaccurate information (e.g., the provider phone number was incorrect or disconnected). Of these 258 providers, 79% confirmed participation with a health plan. Agency follow-ups with the health plans resulted in a finding that 88% of the providers sampled were in fact contracted with the health plan for which they were surveyed. The March 2008 survey focusing on Area 10 included 117 providers, 82% of which confirmed participation with a health plan. Agency follow-up with the health plans resulted in a finding that 95% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

In the April 2008 statewide survey, 273 of the 300 providers were surveyed or could not be surveyed due to inaccurate information (e.g., the provider phone number was incorrect or disconnected). Of these 273 providers, 79% confirmed participation with a health plan. Agency follow-up with the health plans resulted in a finding that 88% of the providers sampled were in fact contracted with the health plan for which they were surveyed. In the April 2008 survey focusing on Area 4, 103 of the 117 providers were surveyed or could not be due to inaccurate information. Of the 103 providers, 83% confirmed participation with a health plan, and Agency follow-up indicated that 84% of the providers sampled were in fact contracted with the health plan for which they were surveyed.

Starting with the May 2008 survey, the Agency's follow-up was expanded to include all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. In the May 2008 statewide survey, the combined results from the survey and the follow-up indicate that 292 (97%) of the 300 sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 11 in May 2008, 116 (99%) had current contracts with the health plans from which they were sampled.

During the second quarter of Year Three, the Agency followed up on and analyzed the June 2008 survey results. As mentioned above, the Agency's follow-up now includes all sampled providers who did not complete the survey, not just those who were surveyed and failed to confirm participation with a plan. In the June 2008 statewide survey, the combined results from the survey and the follow-up indicate that 288 (96%) of the 300 sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 9 in June 2008, 114 (97%) had current contracts with the health plans from which they were sampled.

Surveys were conducted in August, September, October, and November 2008. During the third quarter of Year Three, the Agency followed up on and analyzed the August and September surveys. In the August 2008 statewide survey, the combined results from the survey and follow-up indicate that 291 (97%) of the 300 sampled providers have current contracts with the health plan for which they were surveyed. Of the 117 providers sampled from Medicaid Area 6 (Hardee, Highlands, Hillsborough, Manatee, and Polk Counties) in August 2008, all 117 (100%) had current contracts with the health plans from which they were sampled. The September survey results were very similar,

with 297 (99%) of the 300 providers in the statewide sample having current contracts with the health plan; and with 99 (99%) of the 100 providers in the Medicaid Area 3 sample having current contracts with the health plans for which they were surveyed. The Medicaid Area 3 (Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union, Citrus, Hernando, Lake, Marion, and Sumter Counties) sample contained 100 provider records rather than 117 due to there being 22 provider records for dentists rather than 39.

During the fourth quarter of Year Three, the Agency followed up on and analyzed the October and November 2008 surveys and the January through March 2009 surveys. In the October 2008 survey, the combined survey results and follow-up by Agency staff indicate that 100% of the sampled providers had current contracts with the health plans for which they were surveyed, in both the statewide (300 providers) and Area 5 (115 providers from Pasco and Pinellas counties) samples. The November 2008 survey had the same results, with 100% of the statewide sample (283 providers) and 100% of the Area 8 sample (95 providers from Sarasota, DeSoto, Charlotte, Glades, Lee, Hendry, and Collier counties) confirmed as participating in the health plans from which they were sampled.

In January 2009, there was an increase in the number of health plans and thus, the number of providers that we sampled and surveyed statewide. In the January, February, and March surveys, the combined survey results and follow-up by Agency staff indicated that 99% of the providers sampled statewide had current contracts with the health plans for which they were surveyed, while 100% of the providers in the focused Medicaid Area samples had current contracts with the health plans. The focused areas in January, February, and March 2009 were Area 7, Area 2, and Area 1, respectively.

As of the March 2009 survey, each of the 11 Medicaid Areas has been the focused geographic area of the survey once. Since each geographic area has been sampled, the Agency will now move to quarterly provider network surveys, sampling twice as many providers (i.e., 30) from each health plan, stratified by provider type (primary care providers, individual providers, and dentists) when possible. The survey will focus on statewide samples rather than the Medicaid Area-focused samples each month. During the first quarter of Year Four, the Agency will conduct the first quarterly provider network survey and will begin analyzing the results.

The Agency is also working on the National Provider Identification and provider matching initiatives. When completed, these two initiatives will result in the provider files containing unique identifiers for each provider. This information will shorten the timeframes to collect these necessary data and improve the accuracy of the information. As the encounter data system is fully implemented, this unique identifier will allow the Agency to take additional steps in identifying active providers, as well as determining how many unduplicated providers are participating in the demonstration.

Objective 3: *To improve enrollee outcomes as demonstrated by: (a) improvement in the overall health status of enrollees for select health indicators; (b) reduction in ambulatory sensitive hospitalizations; and (c) decreased utilization of emergency room care.*

(a) During the fourth quarter of Year Three, the Agency continued implementation of the performance measure improvement strategy adopted to achieve the goal of the 75th National Percentile for Healthcare Effectiveness Data and Information Set (HEDIS) measures. The Agency met with the final four health plans that had not yet discussed their corrective action plans. All health plans, including those who met with the Agency previous quarter, submitted their final corrective action plans and commenced work on the interventions. The Agency created a quarterly reporting form, personalized for each health plan, to allow report data to be uploaded into a database for efficient tracking. The forms were distributed to the health plans with the first report due August 17, 2009. The Agency is currently completing construction of the database for use next quarter.

The Agency distributed a policy transmittal to the health plans with the list and specifications of performance measures due in July 2010. An update will be provided in the next quarter in response to changes made by the National Committee on Quality Assurance to several of the HEDIS measures the Agency selected.

Year Two performance measures are due to the Agency on July 1, 2009. Several plans have submitted the performance measure data prior to the deadline. Early preliminary results suggest that the health plans have improved over the previous year.

(b) Due to delays in encounter data collection, the Agency constructed an alternative data resource to examine the effect the demonstration project had on Ambulatory Sensitive Hospitalizations (ASH). This alternative source can provide a precursor tool for measuring ASH criteria until the primary encounter data system becomes fully operational and is generating reliable information. This alternative data is constructed from merging two separate databases within the Agency. The first data source comes from the Hospital Inpatient Discharge Data from the Florida Center for Health Information and Policy Analysis (FCHIPA). FCHIPA is a division within the Agency that collects, validates and analyses an information repository covering all inpatient care provided in Florida. As required by Florida Statute, all hospitals in the state are required to routinely provide FCHIPA with an electronic data set for all their inpatient stays regardless of payer. The second data source is Medicaid claim history covering HMO capitation payments and Fee-For-Service (FFS) inpatient paid claims.

The Medicaid capitation claims identify HMO recipients by Social Security Number (SSN) and their enrollment dates. This data set is matched against the Hospital Discharge Data which contains the patient's SSN and date of admission. The

successful matches (based on SSN+Date) identify those occasions of an inpatient stay that occurred in the same month that Medicaid made a capitation payment to a specific HMO to cover that recipient's care. Thus, this matched data is considered a viable precursor method for identifying HMO covered inpatient care.

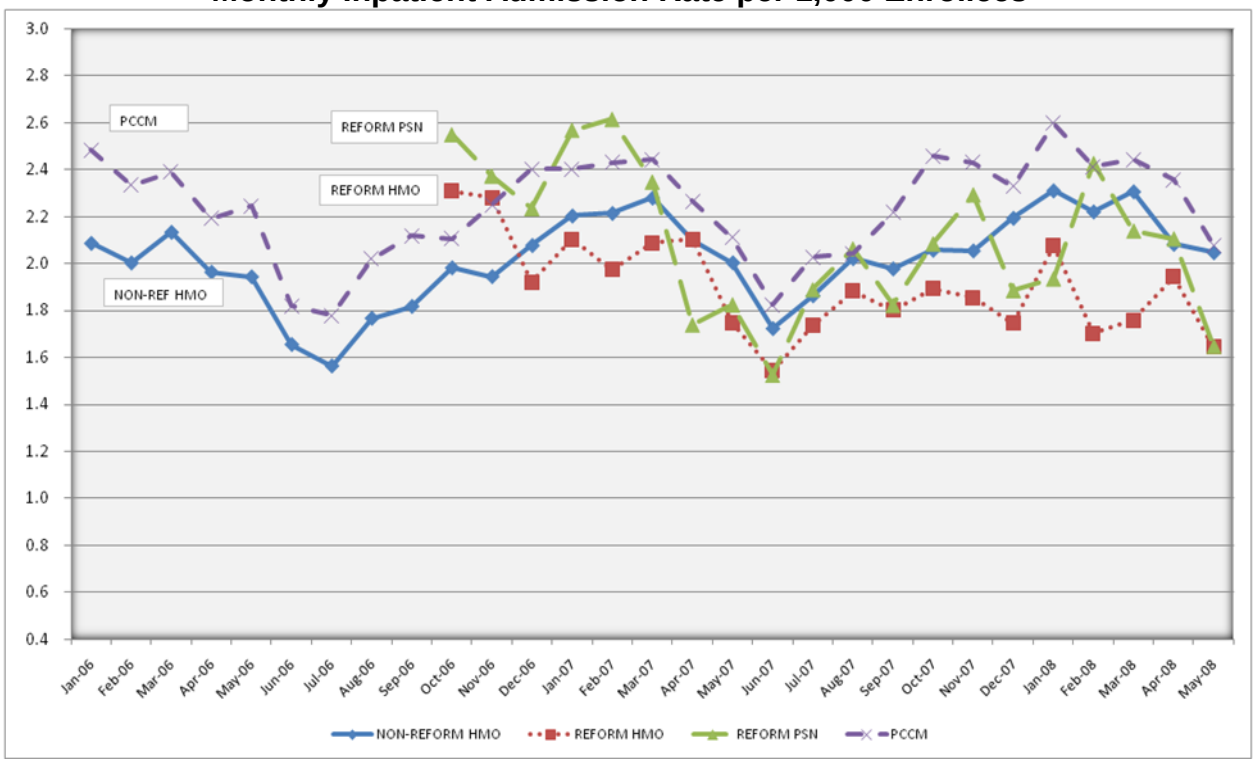
A calculation was applied to this HMO matched data to compensate for missing SSN's that exist in both data resources. Approximately 2% of Medicaid capitation claims data did not have an SSN identified. Approximately 13% of the FCHIPA Hospital Discharge data lacked a valid SSN. In order to measure the rate of success for matching SSN's, an "SSN Comparison Group" was constructed from FFS inpatient claims. The premise is all Medicaid paid inpatient admissions are contained in the Hospital Discharge data. The same SSN+Date matching exercise was performed on this SSN Comparison Group. The level of matching success achieved in this exercise was then applied to the matched HMO inpatient data in order to extrapolate the total volume of HMO inpatient admissions. This FFS comparative matching exercise was performed on 5 years of inpatient data. The average successful matching rate for this Comparison Group was 81.7%. Thus, the matched HMO inpatient data is also defined as representing 81.7% of the total inpatient care provided by the Medicaid HMO's.

The ASH indicators were then applied to this precursor HMO inpatient encounter data. A total of 24 of these indicators were individually calculated and aggregated. The ASH rates of admission were compiled monthly covering January 2006 through June 2008. The ASH rates were prepared for the Reform HMOs, Non Reform HMOs and Reform PSNs. Primary Care Case Management (PCCM) was included to provide comparative reference. For this exercise, the Children's Medical Services Reform PSNs were excluded in order to facilitate a more uniform comparison.

Charts B and C presents the findings from this exercise. These charts demonstrate a measurably lower ASH admission rate for the Reform health plan enrollees.

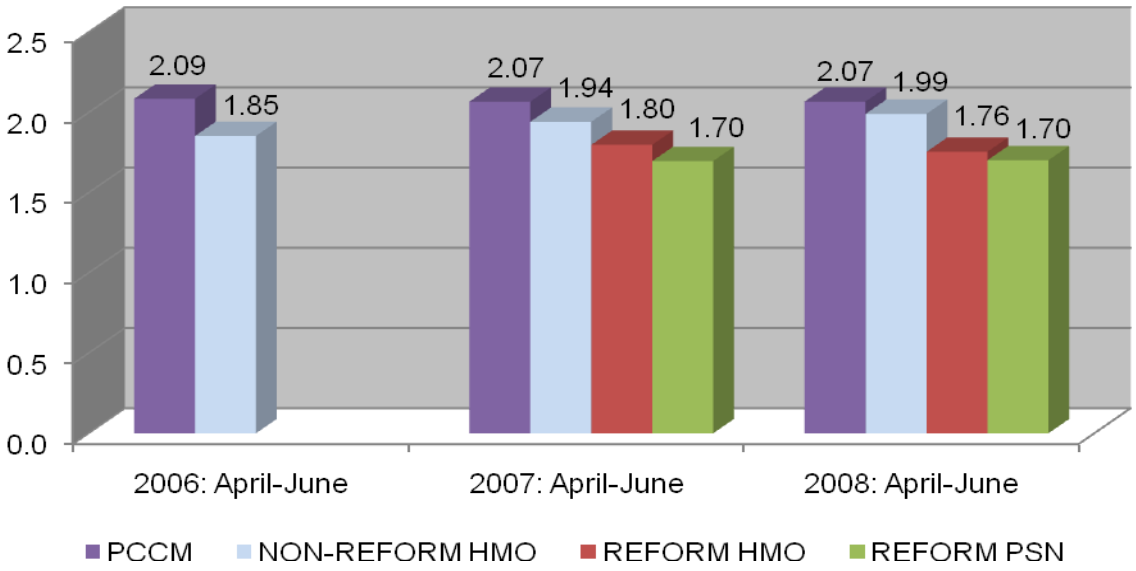
(c) Delays in encounter data collection have affected the Agency's ability to analyze the demonstration project's impact on emergency room utilization. On July 1, 2008, health plans submitted data for the Ambulatory Care HEDIS measure. A component of this measure is emergency department utilization per 1,000 member months. These data will be submitted to the Agency annually and will allow the Agency to trend the impact the demonstration project has had on emergency room use. The second annual submission is due to the Agency on July 1, 2009.

Chart C Ambulatory Care Sensitive Conditions
Monthly Inpatient Admission Rate per 1,000 Enrollees*



* HMO and PSN figures exclude MediKids and the CMS Reform PSNs. PCCM figures exclude CMS, MediKids, and other HMO ineligibles.

Chart D Ambulatory Sensitive Hospitalizations
Comparison of Average Inpatient Admission Rates per 1,000 Enrollee*



* HMO and PSN figures exclude MediKids and the CMS Reform PSNs. PCCM figures exclude CMS, MediKids, and other HMO ineligibles.

Objective 4: *Determine the basis of an individual's selection to opt out and whenever the option provides greater value in obtaining coverage for which the individual would otherwise not be able to receive (e.g., family health coverage).*

For individuals who chose to opt out of Medicaid Reform, the Agency established a database that captures the employer's health care premium information and whether the premium is for single or family coverage to allow the Agency to compare it to the premium Medicaid would have paid. In addition, the Agency enters in the Opt Out Program's database the reason why an individual, who initially expressed an interest in and was provided information on the Opt Out Program from a Choice Counselor, decided not to opt out of Medicaid.

The reasons individuals have chosen to opt out of demonstration include:

(1) primary care physician was not enrolled with a Medicaid Reform health plan and

(2) elected to use the Medicaid Opt Out medical premium to pay the family members' employee portion of their employer sponsored insurance.

The individuals who decided not to opt out:

(a) were not employed,

(b) did not have access to employer sponsored insurance, or

(c) after hearing about opt out decided to remain with their Medicaid Reform health plan where there were not co-pays and deductibles.

Objective 5: *To ensure that patient satisfaction increases.*

The Agency has contracted with the University of Florida (UF) to conduct patient satisfaction surveys throughout the five-year demonstration period. The survey instrument used by UF is based on the *Consumer Assessment of Healthcare Providers and Systems* (CAHPS) *Survey*. The CAHPS Survey is one of a family of standardized instruments used widely in the health care industry to assess enrollees' experiences and satisfaction with their health care. UF has adapted the CAHPS telephone survey component by adding questions specific to the Reform demonstration. The latest report, Enrollee Satisfaction: Year One Follow-Up Survey Report, can be viewed on our website at: http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml.

Summary Information – Enrollee Experience & Satisfaction (Broward & Duval)

The goal of the *Medicaid Reform Enrollee Satisfaction: CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey* is to measure health care experiences and satisfaction levels prior to and throughout the implementation of Medicaid Reform.

Summary Findings: Year One Follow-Up in Broward & Duval Counties:

- For the majority of all comparisons, statistically significant differences are not observed between Broward and Duval Counties.

- Almost half (46%) reported it was always easy to get an appointment with a specialist.
- About 81% of enrollees in Broward County, and 76% in Duval County reported choosing their health plan.
- About 58% of enrollees in Broward County, and 63% in Duval County reported awareness of the Enhanced Benefits Rewards (EBR) Program.
- Over 60% reported awareness of the Choice Counseling Program.
- Approximately 60% rated their overall satisfaction with care at the highest level (level 9 or 10).
- Non-SSI enrollees tended to provide higher ratings of their health care than SSI enrollees.

Summary Findings: Comparison of the Benchmark Survey Results and Year One Follow-Up Survey Results in Broward & Duval Counties:

- Demographics and health characteristics did not differ in any way except for age.
- The percentage rating their overall satisfaction with care at the highest level decreased (66.54% to 59.63%).
- The percentage rating their satisfaction with their personal doctor at the highest level increased (70.19% to 73.41%).

Broward County:

- The percentage rating their overall health care at the highest level declined for the overall, SSI and non-SSI populations.
- For the overall population and among the non-SSI enrollees, the proportion giving their personal doctor the highest rating increased.
- For SSI enrollees, the percentage giving overall plan satisfaction the highest rating declined.
- There was no change in specialty care ratings.
- The percentage of PSN and HMO enrollees rating their personal doctor at the highest level increased.

Duval County:

- With a few exceptions, ratings did not change between 2006 and 2008.
- The percentage rating their overall health care at the highest level declined for the overall population and for non-SSI individuals.
- The percentage of HMO enrollees rating their overall care at the highest level declined.

Select Demographic Characteristics: Broward and Duval Counties:

	Benchmark Survey	Year 1 Follow-Up Survey
Excellent or very good health (For overall health assessment, enrollee responded as "excellent" or "very good")	60.56	59.83
Female (Enrollee Gender)	53.90	54.25
Hispanic/Latino (Enrollee Ethnicity)	20.28	20.35
Black/African-American (Enrollee Ethnicity)	55.50	55.57
SSI (Categorical Eligibility)	19.23	18.91
Mean Age (Of Enrollee)	16.56	15.43

The following tables contain the percentage of program enrollees that reported the "Highest Level of Satisfaction," or a "9 or 10" on a Rating Scale of "1 to 10."

Select Satisfaction Measures: Broward and Duval Counties		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.10	57.37
Overall Satisfaction with Care	66.54	59.63
Personal Doctor Rating	70.19	73.41
Specialist Rating	60.39	63.32

Select Satisfaction Measures: SSI (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	53.39	45.76
Overall Satisfaction with Care	56.41	48.68
Personal Doctor Rating	67.09	67.01
Specialist Rating	64.56	64.35

Select Satisfaction Measures: Non-SSI (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	59.88	60.10
Overall Satisfaction with Care	68.98	62.53
Personal Doctor Rating	70.97	76.64
Specialist Rating	60.29	62.58

Select Satisfaction Measures: SSI (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	55.91	53.12
Overall Satisfaction with Care	59.19	55.38
Personal Doctor Rating	69.41	68.82
Specialist Rating	63.80	58.65

Select Satisfaction Measures: Non-SSI (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	57.57	58.74
Overall Satisfaction with Care	68.40	60.87
Personal Doctor Rating	70.29	71.88
Specialist Rating	55.0	65.88

Select Satisfaction Measures: PSN (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	57.96	56.11
Overall Satisfaction with Care	63.67	60.82
Personal Doctor Rating	70.56	76.19
Specialist Rating	61.93	62.72

Select Satisfaction Measures: HMO (Broward Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.69	57.50
Overall Satisfaction with Care	67.01	59.15
Personal Doctor Rating	68.51	74.41
Specialist Rating	58.63	63.46

Select Satisfaction Measures: PSN (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	58.69	57.50
Overall Satisfaction with Care	67.01	59.15
Personal Doctor Rating	68.51	74.41
Specialist Rating	58.63	63.46

Select Satisfaction Measures: HMO (Duval Only)		
Percent Rating 9 or 10 (Highest Level of Satisfaction)	**Benchmark Survey**	**Year 1 Follow-Up Survey**
Overall Plan Satisfaction	55.33	56.72
Overall Satisfaction with Care	64.01	59.54
Personal Doctor Rating	66.98	69.67
Specialist Rating	49.11	62.07

The projected timeline for the follow-up surveys to be conducted in Broward and Duval Counties are outlined below. Data from the Year Two follow-up survey were collected between March and June 2009. Analyses are currently underway and will be reported in the fall of 2009.

Patient Satisfaction Surveys – Broward & Duval Counties Projected Timeline		
Survey	**Description of Survey Activity**	**Timeline**
Year Two "Follow-Up" Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan during demonstration Year Three.	Winter 2009
Year Three "Follow-Up" Survey	Satisfaction survey data collected from beneficiaries who were enrolled in a Reform health plan during demonstration Year Four.	Winter 2010

Objective 6: *To evaluate the impact of the low-income pool on increased access for uninsured individuals.*

Prior to the implementation of the demonstration, Florida's State Plan included a hospital Upper Payment Limit (UPL) program that allowed for special Medicaid payments to hospitals for their services to the Medicaid population. The demonstration waiver created the Low Income Pool (LIP) program which provides for payments to Provider Access Systems (PAS), which may include hospital and non-hospital providers. The inclusion of these new Provider Access Systems allows for increased access to services for the Medicaid, underinsured, and uninsured populations.

During the first year of the LIP, the following Provider Access Systems received State appropriations for LIP distributions: Hospitals, County Health Departments (CHDs), the St. John's River Rural Health Network (SJRRHN), and Federally Qualified Health Centers (FQHCS). During the first two quarters of Year One, the State approved a PAS distribution methodology and has worked with these PAS entities establishing agreements with the local governments or health care taxing districts.

The services realized through these PAS entities include, but are not limited to, the implementation of case management for emergency room diversion efforts and/or chronic disease management, increased hours and medical staff to allow for increased

access to primary care services and pediatric services, and the inclusion of increased services for breast cancer and cervical screening services.

As required under STC #102 in Demonstration Year Two, the State conducted a study of the cost-effectiveness of the various Provider Access Systems (hospital and non-hospital providers). The State has contracted with the University of Florida to conduct the evaluation of LIP, including cost-effectiveness and the impact of LIP on increased access for uninsured individuals. During the second quarter of Year One, the State held meetings with the University of Florida's Medicaid Reform Evaluation team in preparation for the study required in Year Two of the demonstration.

During the third quarter of Year One, the Agency continued its work with the University of Florida's Medicaid Reform Evaluation team. On January 30, 2007, the Agency received a request for pre-LIP information from the University of Florida's Medicaid Reform Evaluation team. On February 20, 2007, the Agency responded, via e-mail, with the electronic data requested. The data requested included information from the hospital Upper Payment Limit (UPL) program, Disproportionate Share Hospital (DSH) program, and the hospital reimbursement exemption costs. In addition, data from the Florida Hospital Uniform Reporting System and hospital Medicaid audited DSH data were provided. A conference call was held on March 6, 2007, to review the data provided.

During the fourth quarter of Year One, the Agency received a letter on June 8, 2007, from the University of Florida LIP Evaluation team confirming receipt of the electronic pre-LIP data; the letter also requested additional information. The additional information was provided to the University of Florida LIP Evaluation team along with the pre-LIP Milestone data (State Fiscal Year 2005-2006) by July 31, 2007. The LIP Milestone data for Year One of LIP (State Fiscal Year 2006-2007) was due to the Agency from all Providers Access Systems no later than August 15, 2007. This information was shared with the University of Florida LIP Evaluation team in September 2007. The University of Florida and the Agency is using the LIP Milestone data for the evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

During the first quarter of Year Two, the Agency and the University of Florida (UF) LIP Evaluation team continued their work together regarding the overall LIP evaluation, with an emphasis on STC #102. During this quarter, the Agency provided the UF LIP Evaluation team the detail of prior years' Intergovernmental Transfers (IGTs) beginning with SFY 2003-04 through SFY 2005-06. The UF LIP Evaluation team prepared two pre-LIP reports and shared the drafts with the Agency. These reports summarized hospital provider costs for the Medicaid, uninsured, and underinsured populations for SFY 2003-04 and SFY 2004-05.

STC #102, Demonstration Year Two Milestones, states that, "the State will conduct a study to evaluate the cost effectiveness of various provider access systems." This study has been done by the UF LIP Evaluation team. The UF LIP Evaluation Team

provided the cost effectiveness study to the Agency by the third quarter of Year Two (January 2008). The cost effectiveness study is based on the measurements of the LIP Milestone reports provided by the Provider Access Systems. A sample of the LIP Milestone report is provided in the Reimbursement and Funding Methodology document. It should be noted that the LIP Milestone reports represent a snapshot of a 12 month period of time.

The LIP Milestone data collected includes data for hospital Provider Access Systems and non-hospital Provider Access Systems. All Provider Access Systems completed the LIP Milestone report for SFY 2005-06 (referred to as the pre-LIP year, or the base year) and for SFY 2006-07 (Year One). It was determined that the reporting data would be based on the state fiscal periods, rather than the various provider fiscal periods. Provider Access Systems with fiscal years different than July 1st – June 30th had to create data system extracts in order to comply with the Agency's request. The hospital data includes the measurements listed below for Medicaid populations and uninsured/underinsured populations.

- Unduplicated count of individuals served (separated by Inpatient, Outpatient, and Total)
- Hospital Discharges
- Case Mix Index
- Hospital Inpatient days
- Hospital Emergency Department Encounters (categorized by HCPC codes)
- Hospital Outpatient Ancillary Encounters (includes services such as diagnostic, surgical, therapy)
- Affiliated Services (includes services such as hospital owned clinic encounters, home health care, nursing home)
- Prescriptions filled

The non-hospital Provider Access System LIP Milestone report data includes the following, also separated by Medicaid populations and uninsured/underinsured populations:

- Primary Care Clinic Encounters
- Obstetric/GYN Encounters
- Disease Management Encounters
- Mental Health / Substance Abuse Encounters
- Dental Service Encounters
- Prescription Drug Encounters
- Laboratory Service Encounters
- Radiology Services
- Specialty Encounters
- Care Coordination Encounters

The Provider Access Systems input the data for the pre-LIP and Year One LIP Milestones on the Agency LIP web-based reporting tool. This data was then reviewed and extracted for submission to the UF LIP Evaluation team. The UF LIP Evaluation team will use the data (along with data previously submitted such as pre-LIP payments, IGTs, charge, cost, and utilization information) to perform their annual evaluations of LIP. In addition, the LIP Milestone reports were used for the cost effectiveness study. The UF provided a "Plan for Evaluation of the Low Income Pool Program" to the Agency. The cost effectiveness will be measured in the method described below.

> "In general terms, the cost-effectiveness measures the dollar cost per unit of program outcome (CE = Program Cost / Program Outcome), with the primary advantage of a cost-effectiveness study being that the program outcome is measured in 'natural units' (i.e., a volume-based measure) rather than in dollar terms. The primary disadvantage of a cost-effectiveness study is that, when a program has multiple outcomes measured in different natural units, it is not possible to aggregate the different program outcomes into a summary measure. In the case of the LIP program, a cost-effectiveness study of the LIP program thus should be examined: LIP Payments / LIP Program Outcome." (pp 10-11)

The UF LIP Evaluation was received from the University of Florida on April 16, 2008; it was then forwarded to Federal CMS on April 21, 2008. On May 6, 2008, the UF LIP Evaluation was disseminated to the Provider Access Systems. This document includes an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

On June 30, 2008, in accordance with STC #102 of Florida's 1115 Medicaid Reform Waiver, the Agency submitted a letter to CMS along with the Low Income Pool Program Highlights: Year 1 (SFY 2006-07) as prepared by the University of Florida. The Low Income Pool Highlights document was submitted as a supplemental document to amplify some key results from Demonstration Year One of the Florida Low Income Pool program, previously submitted to CMS.

In the fourth quarter of Year Three, the Agency has submitted the SFY 2007-08 Milestone data to the University of Florida. The Milestone data will be used in accordance with STC #102 of the waiver. The Agency looks forward to receiving SFY 2007-08 Milestone in report form from the UF in September 2009. This document will include an evaluation of the impact of LIP on increased access to services for Medicaid, uninsured, and underinsured populations, in addition to the cost effectiveness study (STC #102).

J. Evaluation of Medicaid Reform

Overview

The evaluation of Medicaid Reform is an ongoing process, scheduled to be completed in June 2010. In November 2005, the Agency contracted for this required 1115 Medicaid Reform Waiver evaluation with an independent entity, the University of Florida (UF). This evaluation was designed to incorporate criteria in the waiver, plus those in the Special Terms and Conditions. The Agency developed and submitted the draft evaluation design of the 1115 Medicaid Reform Waiver to CMS on February 15, 2006. The Agency incorporated comments from the CMS Division of Quality, Evaluation, and Health Outcomes, and submitted the final evaluation design of the 1115 Medicaid Reform Evaluation (MRE) to CMS on May 24, 2006. CMS approval was received on June 13, 2006.

The Medicaid Reform Evaluation is a five-year "over-arching" study that will present its major findings in 2010. However, due to the increasing interest in observing preliminary findings much sooner, the Agency, as well as several other external entities, has continued to conduct short term studies to look at specifically identified Medicaid Reform issues. These "interim" assessments will likely continue to occur throughout the five-year evaluation period. Descriptions of the evaluation reports which occurred during the third quarter of Year Three are provided below.

1. Evaluations Affiliated with the Agency or its Contractors

During this quarter of the reporting period, there were no reports on the demonstration associated with the Agency or its contractors.

2. Evaluations Commissioned by Governmental Agencies

Office of Program Policy Analysis and Government Accountability

The Florida Legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA) has conducted several reviews of the 1115 Medicaid Reform Waiver as specified in Chapter 2005-133, Laws of Florida. This law provides that reports focus on issues related to access, choice, quality of care, barriers to implementation, and recommendations regarding statewide expansion. During this quarter, OPPAGA released their ninth and final report on the demonstration waiver. The report entitled, *"Medicaid Reform: Legislature Should Delay Expansion Until More Information Is Available to Evaluate Success,"* can be found at: http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/0929rpt.pdf.

In summary, this report asserts that to date, little data is available to demonstrate the waiver has improved access to and quality of care. However, the Agency has developed a system to track services provided to beneficiaries, and this system should have complete plan service data available in January 2010. Again, this report restates that little data is available on whether the demonstration waiver has produced cost savings, or is more cost-effective than traditional Medicaid. OPPAGA's final

recommendation to the Legislature was not to expand the demonstration waiver until more information becomes available to evaluate the program's success.

The first eight OPPAGA reports on the Medicaid Reform Demonstration can be found at the website link: http://www.oppaga.state.fl.us/reports/health/r08-64s.html.

3. UF Independent Evaluation in State Fiscal Year 2008-2009

UF will continue to coordinate all evaluation activities pertaining to the demonstration. These evaluation activities occur throughout the demonstration, and are described by individual study/report timeframes per the Medicaid Reform Evaluation (MRE) contract between UF and the Agency.

Louis de la Parte Florida Mental Health Institute at the University of South Florida

In addition to the studies already initiated, the Agency is evaluating the mental and behavioral services provided in the demonstration counties (Broward, Duval, Baker, Clay, and Nassau). This study is being conducted jointly by UF and the Louis de la Parte Florida Mental Health Institute at the University of South Florida (USF), through a subcontract between UF and USF. A comparison or "control" group in Orange County has been included in this study, which is intended to provide a typical "picture" of mental health service provision in a non-demonstration county. This will allow UF to evaluate the impact of the demonstration on beneficiaries who are receiving mental health services. The first interim/progress report of the comprehensive mental health study plan have been submitted to the Agency for review, and results should be made available during the next quarterly reporting period.

University of Florida – Fiscal Analysis

A key goal of the demonstration is to achieve greater predictability in Florida's Medicaid expenditures, with the ultimate goal of improved capacity to manage program costs. The first independent evaluation report to look at Medicaid expenditures was released by the Agency in June 2009. The report, "*An Analysis of Medicaid Expenditures Before and After Implementation of Florida's Medicaid Reform Pilot Demonstration*," can be found at:
http://ahca.myflorida.com/Medicaid/quality_management/mrp/contracts/med027/med027.shtml.

The fiscal analysis provided an initial indication of the 1115 demonstration waiver costs in comparison to enrollee expenditures during the pre- and post-demonstration periods. The Agency continues to work with health plans to collect and process encounter data, and once those data are comprehensive, it will be possible to determine precisely what services are purchased with expenditures on individual enrollees over time.

Study Background

For the fiscal analysis, Broward and Duval counties were measured and compared with changes in two other Florida urban counties (see Chart E). The comparison counties (also called control counties throughout the Fiscal Analysis Report) were Hillsborough

and Orange Counties. The study compared the Medicaid program's PMPM expenditures for all demonstration eligible services provided to demonstration eligible enrollees during the two fiscal years prior to implementation of the waiver (SFY 2004-2005 through SFY 2005-2006), to the PMPM expenditures on behalf of enrollees in the demonstration HMOs and PSNs during the first two fiscal years of waiver (SFY 2006-2007 through SFY 2007-2008). In the calculation of the demonstration expenditures, all facility, medical, and pharmacy claims or analogous HMO capitation payment amounts were obtained for all Medicaid enrollees who lived at least one month in Broward or Duval County, and were in an eligibility category that would have made them eligible to participate in the demonstration had it existed during SFY 2004-2005 or SFY 2005-2006.

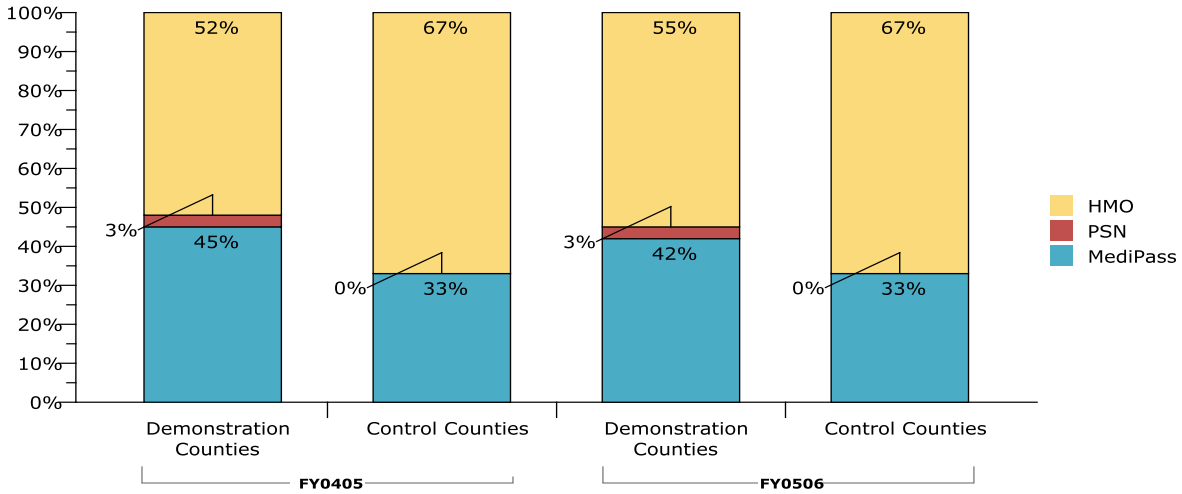
The fiscal analysis *methodology* is described in detail in the actual report, and the study *algorithm* follows the report as an appendix.

***Note*:** According to the Special Terms and Conditions of the demonstration waiver, three eligibility categories referred to as "Medicaid Eligibility Groups" (MEGs) were established for the fiscal analysis study: MEG #1 included individuals with eligibility based on Supplemental Social Security Income (SSI), MEG #2 included Children and Families with eligibility through Temporary Assistance for Needy Families [TANF], and MEG #3 referred to the Low-Income Pool program.

Study Findings: Comparison of Demonstration and Control Counties

Chart E shows HMO, PSN, and MediPass enrollments for the demonstration counties (Broward and Duval), and the control counties (Hillsborough and Orange) for SFY 2004-2005 through SFY 2005-2006. For the two years prior to the implementation of the demonstration waiver, the HMO market penetration rate for both the demonstration and control counties was over 50%, with the control counties having a slightly higher HMO presence. Compared to the control counties, the demonstration counties had a slightly higher MediPass/PSN enrollment, partly due to the lack of PSNs in the control counties. *In general, the proportion of HMO and PSN/MediPass enrollees for the demonstration counties compared to the control counties was similar for both years prior to the pilot program initiation*.

Chart E Comparison of HMO, PSN, and MediPass Enrollment for the Demonstration Counties Compared to the Control Counties for SFY 2004-2005 through SFY 2007-2008*



* Demonstration counties include Broward and Duval, and the control counties include Hillsborough and Orange.

Relative to control counties, Medicaid expenditures in the demonstration counties were $6 PMPM less during the first two years of demonstration compared to the two years prior to the demonstration.

Table 36 provides the average PMPM expenditures for MEG #1 enrollees was $26 lower in the first two years of the demonstration (SFY 2006-2007 through SFY 2007-2008), compared to SFY 2004-2005 through SFY 2005-2006. In the control counties, average PMPM expenditures for MEG #1 enrollees were $150 higher in SFY 2006-2007 through SFY 2007-2008, compared to SFY 2004-2005 through SFY 2005-2006. Thus, relative to the control counties, expenditures for MEG #1 enrollees in the demonstration counties were lower by $176 PMPM during the first two years of the demonstration waiver, compared to the two years immediately before implementation of the demonstration (SFY 2004-2005 through SFY 2005-2006). For MEG #2 enrollees in the demonstration counties, average PMPM expenditures were $4 higher in the first two years of the demonstration compared to the two years prior to the demonstration waiver. However, for MEG #2 enrollees in control counties, average PMPM expenditures were $10 higher in SFY 2006-2007 through SFY 2007-2008 compared to SFY 2004-2005 through SFY 2005-2006.

Table 36
Average PMPM Expenditure for All Enrollees in Dollars

	Broward/Duval (Reform Counties)		Hillsborough/Orange (Control Counties)		Difference-in-Difference (Control — Reform)	
	MEG #1	MEG #2	MEG #1	MEG #2	MEG #1	MEG #2
Pre-Reform Period	809	127	683	126		
Reform Period	783	131	833	136		
Reform — Pre-Reform	-26	4	150	10	176	6

Pre-Demonstration Period: SFY 2004-2005 through SFY 2005-2006; Demonstration Period: SFY 2006-2007 through SFY 2007-2008

Relative to the control counties, Medicaid payments to participating HMOs on behalf of MEG #2 enrollees were greater by an average of $9 PMPM in the first two years of the demonstration waiver compared to the two years prior to the demonstration.

Table 37 shows that **i**n the demonstration counties, the average PMPM expenditures for MEG #1 enrollees was $104 higher in the first two years of the demonstration, compared to the two years prior to reform. In the control counties, average PMPM expenditures for MEG #1 enrollees were $111 higher in the first two years of the pilot compared to two years prior to pilot. Therefore, relative to the control counties, Reform expenditures to HMOs participating in the demonstration were lower by an average of $7 PMPM in the first two years of Reform compared to the two years prior to reform.

For MEG #2 enrollees in the Reform counties, average PMPM expenditures were $12 greater in the first two years of Reform compared to the two years prior to Reform. In the control counties, PMPM expenditures for MEG #2 enrollees were $3 greater in the first two years of Reform compared to the two years prior to reform.

Table 37
Average PMPM Expenditure for HMO Enrollees in Dollars

	Broward/Duval (Reform Counties)		Hillsborough/Orange (Control Counties)		Difference-in-Difference (Control — Reform)	
	MEG #1	**MEG #2**	**MEG #1**	**MEG #2**	**MEG #1**	**MEG #2**
Pre-Reform Period	668	126	512	118		
Reform Period	772	138	623	121		
Reform — Pre-Reform	104	12	111	3	7	-9

Pre-Demonstration Period: SFY 2004-2005 through SFY 2005-2006; Demonstration Period: SFY 2006-2007 through SFY 2007-2008

Relative to the control counties, Medicaid's expenditures for MEG #2 enrollees in PSNs was on average of $34 PMPM lower in the first two years of the demonstration compared to the two years prior to the demonstration waiver.

Table 38 shows the differences in PMPM expenditures were calculated separately for MediPass enrollees and PSN enrollees. Since the PSN enrollment was extremely limited pre-demonstration in the pilot counties and not available at all in the control counties, expenditures by MediPass enrollees are used for comparison. On average, MEG #1 enrollees in PSNs in the demonstration counties had PMPM expenditures that were $95 less in the first two years of the demonstration compared to the two years prior to the demonstration waiver. MEG #1 enrollees in the control counties had $178 greater PMPM expenditures during the first two years of the demonstration compared to the two years prior to reform. Thus, relative to the control counties, Florida Medicaid expended an average of $273 PMPM less on behalf of MEG #1 enrollees in PSNs in the first two years of the Reform demonstration compared to the two years prior to reform. For MEG #2 enrollees in Reform counties, average PMPM expenditures in PSNs were $16 less in the first two years of Reform compared to the two years prior to Reform. For MEG #2 enrollees in the control counties, average PMPM expenditures

were $18 greater in the first two years of Reform compared to the two years prior to reform.

Table 38
Average PMPM Expenditure for MediPass/PSN Enrollees in Dollars

	Broward/Duval (Reform Counties)		Hillsborough/Orange (Control Counties)		Difference-in-Difference (Control —Reform)	
	MEG #1	**MEG #2**	**MEG #1**	**MEG #2**	**MEG #1**	**MEG #2**
Pre-Reform Period	894	128	860	139		
Reform Period	799	112	1038	157		
Reform — Pre-Reform	-95	-16	178	18	273	34

Pre-Demonstration Period is SFY 2004/2005 and SFY 2005/2006; Demonstration Period is SFY 2006/2007 and SFY 2007/2008

In summary, it appears that Medicaid expenditures in Broward and Duval Counties were lower on a PMPM basis during the first two years post demonstration than would have been the case in the absence of the demonstration project. The observed differences are greater among MEG #1 enrollees, and the differences occurred among both HMO enrollees and PSN enrollees. An interim progress report on Year Three of the Demonstration's Fiscal Analysis is scheduled to be submitted to the Agency for review in January 2010, with a final report due June 30, 2010.

University of Florida - Qualitative Survey

One of the components of the evaluation has been a qualitative (previously called longitudinal[4]) study designed to help understand demonstration enrollees' attitudes and beliefs about health and health care, their previous experiences with Medicaid and the overall health care system, and their current experiences under the demonstration.

The primary purpose of this study was to inform the development of further research on demonstrated outcomes. This has now been accomplished, and the independent evaluator will be replacing the qualitative study with an analysis from another area of the demonstration that needs to be assessed in order to further enhance the pilot program. The Agency will be initiating communications with CMS regarding the independent evaluation of this new analysis.

4. Medicaid Reform Evaluation Advisory Committees

Florida Advisory Committee

The Florida Advisory Committee (FAC) was named during the first year of the evaluation, with appointments being made by the Agency Secretary. FAC members represent key stakeholders with strong interests in Medicaid Reform, such as representatives from the state's hospital and managed care industries, the medical association, other health professional groups, advocacy organizations, legislative

[4] This study was originally intended to be longitudinal; that is, it would follow the same recipients over time from before implementation through the end of the study period. However, it proved difficult to locate the same recipients and convince them to participate numerous times.

leadership, or other entities. The FAC meets annually over the five years of the evaluation project, and these meetings provide an opportunity for advisory committee members to obtain current information on the demonstration and the evaluation efforts. The third annual meeting will occur October 27, 2009, at the Agency for Health Care Administration in Tallahassee, Florida.

Technical Advisory Committee

The Technical Advisory Committee (TAC) was selected and appointed by the research team at UF. This committee includes nationally prominent, well-regarded health services researchers known for their expertise in Medicaid and/or the specific research methodologies to be employed in the evaluation studies. A list of the TAC members and their expertise can be found here:
http://mre.phhp.ufl.edu/advisorycommittees/index.htm#tac

The purpose of this committee is to, over the five-year demonstration period, provide the evaluation team with expert advice on technical issues in data analysis and the presentation of findings, serving as both a resource and a quality check. Specifically, the TAC reviews and provides input on the detailed analysis plan for each project. The research team maintains ongoing electronic contact with the TAC members, seeking specific advice, comments, or suggestions whenever necessary.

This year's annual TAC meeting took place on March 27, 2009, at the University of Florida in Gainesville. In addition to the TAC representatives, all project areas of the evaluation were represented by UF research team members who are involved with the analytical details of specified project evaluation strategies and outcomes on a day to day basis. The information exchange between the UF evaluators and the national experts focused on all areas of the demonstration evaluation, and how current research can be improved or adjusted to most appropriately address and assist in resolving critical issues associated with program operations of the demonstration.

K. Policy and Administrative Issues

Current Activities

The Agency continues to identify and resolve various operational issues for both prepaid health plans and FFS PSNs. During this quarter, the Agency's internal and external communication processes continue to play a key role in managing and resolving issues effectively and efficiently.

Policy, administrative and operational issues are generally addressed by four different processes:

- Technical Advisory Panel regular meetings;
- Policy Transmittals and Dear Provider Emails;
- Bi-weekly Reform Health Plan Technical and Operations Conference Calls; and
- FFS PSN Systems Monthly Conference Calls.

All of these forums provide excellent discussion and feedback on proposed processes, and provide finalized policy in the form of the Agency's Dear Provider letters and policy transmittals. Through these forums, the Agency continues its initiatives on process and program improvement. Additional forums were provided to health plans and AHCA headquarters and area office staff to handle the transition of members from Staywell and Healthease health plans to other Reform health plans (see Section A. for further information on transition mitigation activities) and to provide an overview to the health plans on the draft September 1, 2009 health plan contract, which combines Reform and non-Reform, FFS and capitated health plans into one model contract and plan/population type exhibits.

Medicaid Reform Technical Advisory Panel

One Technical Advisory Panel (TAP) meeting was held during this quarter on May 7, 2009. Discussion topics included:

- Updates on legislation, including that Medicaid Reform had not been expanded and that there was legislation to give FFS PSNs a maximum of five years to become capitated (instead of three years);
- Health plan rates, particularly on the upcoming September 1, 2009 capitation rates and the ongoing Managed Care Reimbursement Workgroup;
- Updates on Medicaid encounter data collection, including a presentation on the collection of data in the prior fiscal agent system, discussion regarding the deadline of on or around July 1 for health plans to begin submitted encounter data to the current Medicaid fiscal agent and the current testing with health plans;
- Updates on Enhanced Benefit earnings and expenditures and discussion on the enhanced benefit program and how it impacts the rate setting process;

- Updates on the Choice Counseling efforts, including discussion on referrals to the Choice Counselor's Special Needs and Mental Health Units, mail-in plan change requests, the potential of expanding the Navigator system for use by specialty providers, and an increase in temporary call center staff to handle call volume; and
- Presentation by the University of Florida regarding the demonstration evaluation, including discussion of beneficiary satisfaction and the fiscal analysis and ways to measure cost benefits of the enhanced benefit program.

Policy Transmittals and Dear Provider Letters

During this quarter, our first policy transmittal of the year was sent to the health plans regarding contract year 3 performance measure reporting. The Agency provided a list of performance measures due to the Agency, specifications for such measures and HEDIS National Means and Percentiles that will be used as the performance benchmark for each measure. This was also a repeated topic on the Agency's biweekly technical and operations calls with the health plans.

Biweekly Technical and Operations Calls

This quarter, the Agency conducted seven biweekly Technical and Operational Issues conference calls with health plans and health plan applicants. The purpose of the calls was two-fold: to communicate the Agency's response to issues addressed at a higher level in the Technical Advisory Panel meetings and to respond to plan questions posed through email, telephone inquiries, and previous technical calls.

All health plans are invited to participate, whether they are currently operating in the demonstration counties. Additionally, the calls are publicly noticed in the Florida Administrative Weekly to allow all interested parties to participate. The Agency staffs these calls with administrative experts in all areas of the demonstration, and participants include a variety of stakeholders, such as health plan chief executive staff, government relations and compliance managers, health plan information systems managers and health plan subcontractors.

Approximately 20 participants attended in person and the popularity of the calls is shown by the number of phone lines in active use during the calls. On average 150 phone lines are in active use during the biweekly conference call. During the quarter, the majority of issues discussed continued to be operational in nature. While the transition to the new Medicaid Fiscal Agent and system continued to be a key item, operational issues regarding quality were popular subjects as well. Quality items discussed include the Agency's performance measures initiative, external quality review updates, the Staywell and HealthEase transition, the collection and submission of Medicaid encounter data to the fiscal agent and the Agency's efforts to consolidate and revise its health plan contracts for September 1, 2009.

Other agenda items included:

- Choice Counseling Program updates, including Enhanced Benefit updates;
- 2009 Legislative session update;

- 2009 Contract reporting requirements
- September 1, 2009 capitation rates; and
- Policy transmittals.

Feedback from call participants indicates that the calls are well received, a good forum for discussion of technical and operational issues, and an avenue for quick discussion and feedback on identified operational issues.

FFS PSN Systems Monthly Conference Calls

The purpose of these calls is to provide a forum to discuss claims processes and enrollment file issues that are unique to the FFS PSN model. The PSNs are encouraged to submit questions and/or issues in advance in order for systems research to occur internally at the Agency (or between the Agency and the Agency's Medicaid Fiscal Agent). Agency participants included management and key technical staff of the Agency's PSN Policy and Contracting Unit, Data Unit, Contract Management Bureau, Area Office staff and Bureau of Managed Health Care staff who are responsible for monitoring the health plans. PSN participants include managing staff as well as key staff responsible for oversight of claims processing functions and key staff at the PSNs contracted TPAs.

During the quarter, working through issues with the new Florida Medicaid Fiscal Agent system continued to be the prime focus of the calls. The volume of new Fiscal Agent system issues has decreased as many implementation issues have been addressed.

A summary of key items addressed through this process included the following:

- Claims denial and clarification of denial edits;
- Conversion of providers authorized by the PSNs to bill directly;
- Potential duplicate claim processing;
- Claims not appearing on the plan-specific electronic remittance voucher; and
- Issues relative to the systems freeze due to the transition of the Florida Medicaid Management Information System (FMMIS).

Once operational systems changes are resolved, the Agency intends to work with the PSNs, key stakeholders and the Medicaid fiscal agent to modify the current claims process for FFS PSNs. The modification is designed to streamline the claims processing function by removing the claims processing step that includes the providers submitting claims to the FFS PSNs and the FFS PSNs having to accept and transmit the authorized claims to the Medicaid Fiscal Agent; and instead allow providers to submit claims directly to the Medicaid Fiscal Agent and have the FFS PSNs authorize the claims through the Medicaid Fiscal Agent for payment.

In addition to these calls, the Agency continued to coordinate technical assistance calls between specific providers and their PSNs to assist providers in getting their claims issues addressed. However, while this function is still available, only a couple of providers have used it this quarter.

September 1, 2009 Contract Draft Review Call

The Agency held a conference call on June 10, 2009, with all health plan contractors and plan applicants in order to provide an overview of the new September 1, 2009 contract. A first draft of the contract was released to the health plans prior to the call and Agency staff led the health plan through major changes in contract requirements and general contract structure. Health plans were given until June 25 to provide comments and request changes to the proposed contract and a future call was scheduled in July to discuss the Agency's review of those comments.

Major contract requirement changes reviewed included:

- Eliminates direct marketing;
- Streamlines reporting requirements and a draft health plan report guide, companion to the new contract, was created;
- Deletes the Agency medical record review for health plans that are accredited and increases the medical record review for health plans not accredited to include primary care providers' sites that serve 10 or more enrollees;
- Requires health plans to track and report complaint totals;
- Allows health plans to provide a $20 per patient as an incentives for completing a plan of care or receiving preventative services;
- Strengthens and clarifies the Sanction section;
- Eliminates arbitration as a method of resolving disputes;
- Prohibits off-shoring of recipient protected health information;
- Specifies timelines for encounter data submission;
- Clarifies the unborn activation process;
- Specifies good cause language for use in member handbooks;
- Clarifies the process by which plans may request involuntary disenrollment of a member;
- Requires member handbooks to include information regarding:
    - Plans must include explanation of 90-day change period,
    - Good cause change language must be included,
    - Plans must provide adult members with information re advance directives,
    - Plans must advise members how to obtain information about quality enhancements,
    - Uniform language on how to report suspected fraud or abuse.
- Requires performance measures for transportation;
- Increases timeframe for health plans to notice the Agency about withdrawal or termination from 90 days to 120 days;
- Adds pediatric specialist network requirements;
- Adds new reporting requirements regarding new providers and provider terminations; and
- Adds minimum contents of required fraud and abuse prevention plan.

Attachment I
PSN Complaints/Issues

PSN Complaints/ Issues April 1, 2009 – June 30, 2009	
PSN Informal Issue	**Action Taken**
1. A PSN member's mother contacted the Agency and stated that the PSN will not provide necessary specialty services.	➲ The PSN reported to the Agency that it came to an agreement with the non-participating provider and services were resumed. The member's parent is satisfied.
2. A PSN member's spouse contacted the Agency and reported that the member was diagnosed with an urgent medical condition and needs a referral for specialty care.	➲ The PSN reported to the Agency that the primary care provider had failed to do the paperwork to obtain a prior authorization for a consultation, causing the member to be turned away by a second provider. The PSN intervened and arranged for an authorization to be issued immediately. PSN caseworkers are now managing the member's care.
3. A PSN member contacted the Agency and stated that she needs a specialist referral but the PSN told her this specialty is only available for children and she should change plans.	➲ The PSN reported to the Agency that it provided a specialist willing to see the member, but that despite numerous attempts to contact the member to confirm an appointment had been made, the member did not return any calls. The issue was closed.
4. PSN staff from a member's new plan requested Agency assistance to ensure that the member receives necessary care from the member's former plan until the transition is completed.	➲ Agency staff confirmed that the current/former health plan had arranged for outpatient services at the family's request and that all services are being provided until the transition to the PSN.
5. A PSN member contacted the Agency and reported being billed by a provider who will not continue to provide services until payment is received.	➲ The PSN reported to the Agency that it counseled the provider and arranged for services to continue. The member will not be billed again.
6. A PSN member's mother contacted the Agency requesting additional home health hours for a non-medically necessary reason.	➲ The PSN reported to the Agency that the member's mother's request is based on convenience rather than medical necessity. The PSN advised the mother of her grievance rights.

Attachment II
HMO Complaints/Issues

HMO Complaints/Issues April 1, 2009 – June 30, 2009	
HMO Informal Issue	**Action Taken**
1. An HMO member contacted the Agency and stated that the HMO is delaying approval of authorization for urgent treatment.	➲ The HMO reported to the Agency that it worked with the primary care provider's office staff to assist in preparation of the prior authorization request. The prior authorization was promptly approved and treatments were scheduled. The member is satisfied.
2. An HMO member contacted the Agency and reported needing a specialist referral but the HMO is not helping to identify a provider.	➲ The HMO reported to the Agency that its subcontractor provided the member's parent with a list of specialists. The member's mother made an appointment and is satisfied. The HMO is providing ongoing support.
3. A provider contacted the Agency and reported that the HMO has not paid the provider's claims.	➲ The HMO reported to the Agency that it received and processed recredentialing documents and then submitted the provider claims for payment. The claims were paid over a period of a few weeks, and the provider is satisfied.
4. An HMO member's mother contacted the Agency and reported that the HMO told her certain specialty services are not covered by the plan.	➲ The HMO worked with the family to resolve the issue. The HMO reported to the Agency that specialists were provided and HMO staff explained to the member's mother that the member's plan card is sufficient to access the necessary specialty care.
5. A provider contacted the Agency and reported that the HMO denied claims for services given to a now deceased individual.	➲ The HMO reported to the Agency that it will not pay the claims because the provider did not check eligibility before providing services and did not attempt to get a prior authorization to treat.
6. An HMO member contacted the Agency and reported that the HMO has not given prior authorization for treatment the member says is urgently needed.	➲ The HMO reported to the Agency that it immediately approved prior authorization and made the item available to the member. The HMO member refused to pick up the item because she is attempting to get disenrolled from the plan and managed care by claiming the HMO is unresponsive. The Area Office will not approve a good cause disenrollment request for this reason. The beneficiary was disenrolled from the plan as the plan stopped providing services in the beneficiary's county of residence.
7. An HMO member's mother reported to the Agency that the member's primary care provider has been unresponsive to requests to submit prior authorization requests to the HMO for necessary services.	➲ The HMO reported to the Agency that it contacted the primary care provider and obtained and approved the prior authorization request. Services were dispensed and the member's mother is satisfied.

HMO Complaints/Issues April 1, 2009 – June 30, 2009	
HMO Informal Issue	**Action Taken**
8. A dual-eligible HMO member contacted the Agency and reported being balance billed by a provider for the outstanding amount on a denied crossover claim.	➲ The HMO determined that the claim denial was correct and advised the provider that they may not balance bill the member.
9. An HMO member's father reported to the Agency that he is unable to arrange services for the member because the HMO and its subcontractor do not have information that lists him as the custodial parent.	➲ The HMO reported to the Agency that it corrected the member database and advised the member's father that he could proceed to obtain necessary care for the member.
10. An HMO member contacted the Agency and stated that the HMO subcontractor is denying authorization for specialty services.	➲ The HMO reported to the Agency that it expedited the authorization process and made all necessary approvals. The member was notified to begin accessing necessary services.
11. A provider contacted the Agency and stated that the HMO is denying claims in error.	➲ The HMO reported to the Agency that it worked with the provider to review the claims and most of them were paid. An HMO representative is working with the provider to correct the remaining claims so that they will be paid. The provider is satisfied.
12. An HMO member's mother reported to the Agency that she is receiving demands for payment of a balance due from a provider on claims that the HMO has denied.	➲ The HMO reported to the Agency that it researched the claim and paid it. The member's mother is satisfied.
13. A provider contacted the Agency and reported that the HMO is denying claims because it says the member was not active in the plan on the dates of service.	➲ Agency staff checked FMMIS and confirmed that the member was active on the dates of service. The HMO reported to the Agency that it reprocessed the claims and they were paid. The provider confirmed that payment was received. The HMO notified the member's mother that the issue was resolved.
14. An HMO member contacted the Agency and stated he needs urgent treatment for a diagnosed condition but the hospital offering these treatments does not participate in the HMO.	➲ The HMO reported to the Agency that it worked with the member, primary care provider, and specialist to identify a plan of care. The HMO also educated the member on how to choose a new plan because the HMO was ending operations in the county soon. The member is satisfied.
15. An HMO member contacted the Agency and reported that the HMO told her she had exceeded benefit limits for certain services and could not access more at this time.	➲ The HMO reported to the Agency that it worked with the member to help her manage one service better. The HMO and member determined the other service was unrelated to the member's healthcare and the plan.
16. An HMO member's mother contacted the Agency and reported that the HMO will not authorize a new provider to complete the services that were previously authorized for a different provider.	➲ The HMO reported to the Agency that it reached out to the member's mother immediately to complete arrangements for the rest of the authorized services.

HMO Complaints/Issues April 1, 2009 – June 30, 2009	
HMO Informal Issue	**Action Taken**
17. An HMO member's parents reported to the Agency that they are being balance billed by a provider for claims that were denied by the HMO.	➲ The HMO reported to the Agency that it made the necessary primary care assignment change so that the claim would pay. The member's parents and provider are satisfied.
18. An HMO member's mother reported to the Agency that the HMO has not issued Enhanced Benefits credits even though the associated claims have been paid.	➲ The HMO acknowledged internal problems with Enhanced Benefit credits getting on member accounts. The issues with the credits have been fixed and the situation is resolved.
19. An HMO member's parent contacted the Agency and reported being unable to obtain necessary items because the usual provider does not participate in the current plan.	➲ The HMO reported to the Agency that it has agreed to authorize services as necessary. The member's parent is satisfied.
20. An HMO member contacted the Agency and stated that the HMO is not authorizing necessary services.	➲ The HMO reported to the Agency that it verified that the member had received requested services. The HMO also researched other concerns of the member and determined that the member is receiving all necessary services. The member is satisfied.
21. An HMO member's parent contacted the Agency and stated she is being billed for services after the HMO denied the provider's claim, on the grounds the member was not active on the date of service.	➲ The HMO reported to the Agency that it advised the provider not to bill the member's parent for the balance due. The HMO will accept the claim for reprocessing but since the provider did not obtain prior authorization, the provider has been advised that it may not pay.
22. An HMO member's parent contacted the Agency and reported that a provider made the parent pay for services upfront because the member's Medicaid number was not yet active. The provider now refuses to reimburse the parent after the HMO denied the claim because the provider is non-participating.	➲ The HMO counseled the provider not to attempt collecting pre-payments from Medicaid in the future. The provider has agreed to reimburse the parent immediately. Since the provider was in the HMO network, the claim will pay once it is resubmitted.
23. An HMO member's mother contacted the Agency and stated that a provider refused services to the member and a sibling because the parent could not verify her legal status in the U.S.	➲ The HMO reported to the Agency that the provider stated he was only trying to confirm the parent's identity for billing purposes but suggested that the parent might want to find another provider. The HMO gave the parent a list of other providers convenient to her home and she agreed to choose one for future visits.
24. An HMO member's mother reported to the Agency that she is being balance billed by a provider because the HMO denied their claim.	➲ The HMO reported to the Agency that it did not pay the claim because another provider was listed as the primary care provider. The HMO retroactively changed the primary care provider assignment and advised the provider to resubmit the claim for payment. The provider agreed not to try to bill the member's family. The member's mother was notified of the resolution.

HMO Complaints/Issues April 1, 2009 – June 30, 2009	
HMO Informal Issue	**Action Taken**
25. A provider contacted the Agency and stated that the HMO denied a claim even though the provider is participating in the HMO network and had previously treated the member.	➲ The HMO reported to the Agency that the provider was confused about the claims process. The HMO had not denied any claims and approved a prior authorization request so that the provider could bill for the service in question. The provider is satisfied.
26. A provider contacted the Agency and reported having claims denied by the HMO.	➲ The HMO acknowledged that denials are occurring due to an internal programming problem. The HMO reported to the Agency that it is correcting the problem and the provider has been advised that all previously denied claims will be reprocessed and paid.
27. An HMO member's parent contacted the Agency and stated that the HMO's member database does not show the member. The member urgently needs a procedure that has already been scheduled.	➲ The HMO reported to the Agency that the member's information was not downloaded into the HMO's member database due to a file transmittal problem, which was corrected immediately. The HMO found no procedure was scheduled, the parent only wanted a consultation. The HMO instructed the parent on how to obtain a referral for a consult from the primary care provider. The member's parent is satisfied.
28. An HMO member contacted the Agency and stated that she was unable to obtain services because the HMO said she is not an active member.	➲ The HMO reported to the Agency that it worked out a balance billing issue and obtained assurance that the member's provider will continue to see the member once she enters her new plan in June 2009. The member is satisfied and the provider has been educated on Medicaid policy.
29. A provider contacted the Agency and stated that the HMO denied a claim because the beneficiary was not shown in the member database.	➲ The HMO reported to the Agency that it corrected its member database and paid the claim.
30. An HMO member contacted the Agency and reported having an urgent health care need and being unable to obtain a provider referral from the HMO subcontractor.	➲ The HMO reported to the Agency that its subcontractor identified two providers willing to accept the member and the member was notified. The member is satisfied.
31. An HMO member's parent stated that the HMO subcontractor authorized services for the member but then denied the subsequent provider claim. The member's parent is being held responsible.	➲ The HMO reported to the Agency that it did not deny the claim but rebundled like services and then paid the total amount. The provider was notified.
32. An HMO member reported to the Agency that the HMO refused to authorize an urgently needed service.	➲ The HMO reported to the Agency that it uses an alternative to the item requested by the member. The member's primary care provider agreed the substitute is equally effective and the HMO immediately authorized it. The member is still not happy but the HMO and Agency staff agree the issue is resolved.

HMO Complaints/Issues April 1, 2009 – June 30, 2009	
HMO Informal Issue	**Action Taken**
33. A provider contacted the Agency and stated that the HMO denied a prior authorization request for a member to be seen by a specialist. The provider stated that this is an urgent matter.	➲ The HMO reported to the Agency that the provider had submitted the prior authorization request to the wrong entity and that the plan approved it immediately once the HMO received it. The member's parent made an appointment with a specialist and is satisfied.
34. An advocate contacted the Agency and stated that the HMO denied services to a member and put up extensive roadblocks when the member tried to access other necessary services.	➲ The HMO reported to the Agency that it worked directly with the member and advocate to arrange for necessary services. All parties are now satisfied that the member's needs are being met.
35. An HMO member's mother reported to the Agency that the HMO and its subcontractor will not provide a requested referral and deny the member is active.	➲ The HMO reported to the Agency that the member had contacted the wrong subcontractor. The HMO had its subcontractor arrange an appointment for the member immediately.
36. A provider contacted the Agency and stated that the HMO denied a claim because they say the member was not active.	➲ Agency staff confirmed in FMMIS that the member was active on the date of service. The HMO reported to the Agency that it corrected the member database and a check was issued to the provider.
37. An HMO member's mother reported to the Agency that a provider is unwilling to continue services because the HMO is not paying claims.	➲ The HMO reported to the Agency that it corrected the initial problem and followed up to correct a balance billing problem. The member's parent is very pleased with the good customer service.
38. An HMO member's mother reported to the Agency that she is unable to obtain a specialist referral from the HMO.	➲ The HMO reported to the Agency that it did outreach to the parent to educate her on what requested services are covered. The HMO will continue to assist the parent to obtain covered services.
39. A provider contacted the Agency and reported that the HMO denied a claim because they say the member was not active on the date of service. The provider stated that an eligibility check indicated that the member was active on the date of service.	➲ The HMO reported to the Agency that the claim was never listed as received. The HMO asked the provider to resubmit the claim for payment. The HMO confirmed that the member was active on the date of service.
40. An HMO member's grandparent reported to the Agency that they are being balance billed by a provider whose claim was denied by the HMO. The HMO stated the member was not active on the date of service.	➲ The HMO reported to the Agency that the beneficiary was actually fee-for-service on the date of service, which was a different date than the member's grandparent cited. The HMO educated the provider and the member's grandparent on how to submit claims for payment. The grandparent is satisfied.
41. An HMO member contacted the Agency and stated that the HMO will not issue a member card to the beneficiary because they say she	➲ The HMO reported to the Agency that it updated its member database and issued the requested card to the member.

HMO Complaints/Issues April 1, 2009 – June 30, 2009	
HMO Informal Issue	**Action Taken**
is giving an incorrect address. The member states her address is correct and is reflected in FMMIS.	
42. An HMO member's parent contacted the Agency and reported that the HMO denied a request for equipment for the member and referred the member's parent to Medicaid for approval.	➲ The HMO reported to the Agency that the member's primary care provider said the equipment was not medically necessary. The HMO stands by the denial. This was explained to the member and the member understands.
43. An HMO member reported to the Agency that the HMO will not provide necessary medication even though the primary care provider has filed a prior authorization request.	➲ The HMO reported to the Agency that the requested medication is not on the plan's formulary. The member's primary care provider agreed to substitute another medication and the HMO refused the member's request. The member went through the HMO's grievance process and lost. The member did not follow through with a request for a fair hearing.
44. An HMO member contacted the Agency and stated he was unable to get the HMO to reimburse him for out-of-pocket payments for services.	➲ The HMO reported to the Agency that it made numerous attempts to contact the member and send him a reimbursement form, but the member has not contacted the Medicaid Area Office or HMO so the issue was closed.
45. An HMO member contacted the Agency and reported needing services but that the HMO subcontractor denied the member is in the plan at this time.	➲ The HMO reported to the Agency that its Member Services unit worked with the custodial case manager to verify eligibility and schedule an appointment for services. The member is satisfied.
46. An HMO member contacted the Agency and reported being denied necessary services by the HMO subcontractor. The member wanted to file for a Medicaid Fair Hearing.	➲ The HMO reported to the Agency that it worked with its subcontractor and the member's primary care provider to assess the member's needs. After review the HMO approved the requested services. The member is satisfied and withdrew the hearing request.
47. An HMO member contacted the Agency to report needing authorization for a new wheelchair.	➲ The HMO reported to the Agency that the member's wheelchair was recently repaired and is in good order. The member's primary care doctor may submit an authorization request for a new wheelchair if medically necessary.
48. An HMO member contacted the Agency and reported needing a primary care provider and to needs medications filled.	➲ An HMO that is accepting new patients found a primary care provider for the member. Agency staff gave the member their names and phone numbers in case he needs further assistance.
49. An HMO member contacted the Agency and stated that he needs to have spinal surgery scheduled with a specialist.	➲ The HMO reported to the Agency that the member's primary care provider submitted an authorization for testing (MRI, CAT scan) which has been approved. Once the testing is

HMO Complaints/Issues April 1, 2009 – June 30, 2009	
HMO Informal Issue	**Action Taken**
	complete, the member will be seeing his specialist, for whom he has a referral. The member has the HMO's direct phone number if he should have additional concerns.
50. An HMO member contacted the Agency wanting authorization to see a specialist located in Maryland.	➲ Agency staff emailed the member and requested that she have her doctor or the specialist contact the HMO to request authorization.
51. An HMO member contacted the Agency and reported receiving a bill for therapy services.	➲ Agency staff notified the provider that they will have to bill straight Medicaid.
52. An HMO member reported to the Agency trouble locating a primary care provider.	➲ Agency staff verified that the member has been assigned a primary care provider by the HMO.
53. An HMO member contacted the Agency and reported being in the process of getting braces and stated that the HMO is no longer willing to complete the treatment process.	➲ The HMO reported to the Agency that it is working with the dental provider to get the claims paid.
54. An HMO member contacted the Agency and reported having several issues including selection of a primary care provider, needing a wheel chair, and needing surgery.	➲ The HMO reported to the Agency that its case management team was able to assist the member with these issues.
55. An HMO member contacted the Agency and reported having changed primary care providers numerous times and not receiving appropriate care.	➲ The HMO reported to the Agency that its case management team was able to help the member with their issues.
56. An HMO member's mother reported to the Agency that she was being billed $2449.73 for her son's medication, which should have been paid by the HMO. The mother had contacted the pharmacy, which insisted it was not in the HMO network, but the HMO assured the mother that the pharmacy is in the network. The mother attempted several times to submit the invoice to the plan, but the HMO does not appear to have records of receiving it.	➲ Agency staff verified that the member was covered by the HMO on the date the medication was ordered by the physician. Agency staff contacted the HMO regarding the pharmacy bill and the mother's difficulties in getting a response from the plan. The HMO responded and authorized payment to the pharmacy, as well as instructing the pharmacy not to bill the member again. The HMO notified the member's mother that the issue is resolved.
57. An HMO member contacted the Agency and reported wanting to continue seeing a non-participating specialist.	➲ The HMO reported to the Agency that it contacted the member and is working with the non-participating provider.
58. An HMO member contacted the Agency and reported being in need of emergency dental services.	➲ The HMO reported to the Agency that an HMO representative reached out the member and provided assistance.